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REPORT BY THE

Comptroller General

OF THE UNITED STATES

Experiments Have Not Demonstrated Success Of Competitive Fixed-Price Contracting In Medicare

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The results of Medicare's three competitive fixed-price experiments have varied. Contractor performance ranged from satisfactory in Maine to unsatisfactory in Illinois. Contractor performance in upstate New York is now considered satisfactory after an initial 6-month period of unsatisfactory performance. In the Illinois experiment, and to a lesser extent in New York, performance and beneficiary and provider services deteriorated during and after contractor changeover, and program payments were not adequately controlled.

GAO does not believe the Congress should give HHS the authority to expand this form of contracting on a large scale at this time because the experiments have not demonstrated that competitive fixed-price contracting will work successfully in Medicare.

UNITED STATES GENERAL ACCOUNTING OFFICE

HRD-82-17
DECEMBER 1, 1981

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

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The Honorable Charles B. Rangel
Chairman, Subcommittee on Oversight
Committee on Ways and Means
House of Representatives

The Honorable Andrew Jacobs, Jr.
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

At the request of Chairman Rangel, we have reviewed the three experimental fixed-price contracts in Medicare part B as a followup to our June 29, 1979, report to the Congress, "More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing" (HRD-79-76). As requested, our review focused principally on the experimental contract in Illinois. We also addressed the Health Care Financing Administration's progress in implementing contractor performance standards and in carrying out other recommendations in our June 1979 report.

We requested comments from the Department of Health and Human Services, the Health Insurance Association of America, the Blue Cross and Blue Shield Associations, and the three contractors involved in the experiments. Written comments were received from all parties, except one experimental contractor, and were considered in finalizing the report.

As discussed with your offices, we are sending copies of the report to the congressional committees interested in these issues; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and other interested parties.

Charles A. Bowsher
Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CHAIRMEN,
SUBCOMMITTEES ON HEALTH AND
OVERSIGHT, HOUSE COMMITTEE
ON WAYS AND MEANS

EXPERIMENTS HAVE NOT DEMONSTRATED SUCCESS OF COMPETITIVE FIXED-PRICE CONTRACTING IN MEDICARE

DIGEST

At the request of the Chairman, Subcommittee on Health,[1] House Committee on Ways and Means, GAO reviewed three competitively awarded fixed-price contracting experiments in Medicare as a followup to its June 29, 1979, report to the Congress, "More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing" (HRD-79-76). In that report GAO expressed some concerns about the potential adverse impact of competitive fixed-price contracting on the Medicare program. (See pp. 8 to 10.)

The results of Medicare's three fixed-price experiments have varied. Contractor performance has ranged from satisfactory in the Maine experiment to unsatisfactory in the Illinois experiment. Performance in upstate New York is now considered satisfactory after an initial 6-month period of unsatisfactory performance.

There were different circumstances associated with each experiment that weighed heavily on the results. Although much can be learned from these experiments, GAO believes they are inconclusive as to whether the broad application of competitive fixed-price contracting in Medicare can produce administrative cost savings without unacceptable negative effects on program payments and services.

To use competitive fixed-price contracting in the Medicare program, except in experiments, the Congress would have to provide HHS with authorizing legislation. GAO believes such a legislative change would be premature at this time. On the other hand, GAO does not have a closed mind on this issue. If and when a competitive fixed-price procurement approach can be designed and

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[1] The request was from Congressman Charles B. Rangel, then Chairman of the Subcommittee on Health. He is now Chairman of the Subcommittee on Oversight.

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implemented to assure a consistently acceptable or improved level of performance in terms of beneficiary and provider services and accuracy of program payments, GAO would be willing to reexamine the issue. (See p. 72.)

THE MAINE EXPERIMENT

Blue Shield of Massachusetts (BSM) completed the final year of its fixed-price contract to process Medicare part B claims in Maine on September 30, 1981. The Health Care Financing Administration (HCFA) estimated that it saved $341,400 by awarding this contract on a competitive basis. BSM's performance has been satisfactory and better than its performance under a traditional cost-reimbursable contract to process similar claims in Massachusetts. The performance penalties associated with the fixed-price contract act as a major incentive for effective performance. The better performance under the fixed-price contract may also be partly attributable to the performance standards developed for the experiments. (See pp. 21 to 24.)

Although the transition of carrier responsibilities in Maine went well, this may be largely because BSM kept many of the claims processing features of the previous carrier, which maintained consistency in payments to providers and eliminated potential problems arising from an entirely new processing system. Because of this approach, however, BSM had to maintain a basically separate staff and was not able to benefit from potential economies of scale from having the same system for both Maine and Massachusetts. (See pp. 26 to 29.) BSM's financial reports indicate that the company has incurred a loss on the contract. (See p. 25.)

THE NEW YORK EXPERIMENT

Blue Shield of Western New York (Buffalo Blue Shield) is in the third year of its experimental fixed-price contract to process part B claims for upstate New York. The experiment saved an estimated $10.8 million in administrative costs, and is progressing smoothly after overcoming some initial performance problems. The transition phase of the experiment was completed successfully, and Buffalo Blue Shield was able to meet its scheduled startup dates for processing claims from the prior carriers despite delays in some transitional tasks. (See pp. 33 to 37.)

Buffalo Blue Shield encountered difficulties when it began processing claims, however, resulting in large backlogs of claims and correspondence and high clerical error rates. It was able to straighten out these initial problems after about 6 months, and HCFA now considers the carrier an above-average performer. (See pp. 38 to 40.)

Buffalo Blue Shield's initial difficulties were caused largely by problems that could be experienced by any Medicare carrier in taking over a new service area. They included a new and inexperienced staff, medical policy differences between Buffalo Blue Shield and the prior carriers, and the difficulty of converting files from the prior carriers. (See pp. 40 to 44.)

THE ILLINOIS EXPERIMENT

Medicare's part B fixed-price contracting experiment in Illinois has been a difficult experience for the program, the Government, beneficiaries and providers, and perhaps the contractor itself. Performance of the contractor--Electronic Data Systems Federal Corporation (EDSF)--has remained substandard under the terms of the contract during the more than 2 years it has processed claims in Illinois. While EDSF's performance has improved and more recently has compared favorably with the previous contractors, serious deficiencies continue to exist, particularly in beneficiary services and the administration of program payments. (See pp. 52 and 53.)

EDSF's payment errors from contract inception to June 30, 1981, have exceeded $67.6 million. While overpayments and underpayments have been almost equal, adjustments favorable to claimants have far exceeded overpayment adjustments, and an estimated $27.7 million in overpayments remains unrecovered. The problematic nature of the contract has required HCFA to use far more resources for monitoring than originally planned, including a special unit established to monitor EDSF exclusively. The $20.6 million estimated savings in administrative costs from the award process and the contract penalties HCFA has collected have been significantly eroded by the Government's additional monitoring costs and the excessive overpayment errors. (See pp. 62 to 65.)

HCFA's monitoring of EDSF's activities during the transition of carrier responsibilities was limited. When problems surfaced after EDSF began processing claims, neither EDSF nor HCFA devoted sufficient attention to pinpointing the causes. Thus, problems went undiscovered and continued to surface during the balance of the contract. (See pp. 53 to 61.)

RECOMMENDATION TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

The Secretary should direct HCFA to analyze the large amounts of unrecovered overpayments in Illinois--now estimated to be about $27.7 million. Such an analysis might identify patterns to these overpayments and result in the recovery of some of this money. (See p. 67.)

AGENCY COMMENTS AND GAO'S EVALUATION

HHS concurred with GAO's recommendation and said it would make an analysis of the amount of estimated unrecovered overpayments by EDSF, causes of these overpayments, corrective action taken to date, further corrective action needed, and recovery plans. (See p. 67.)

HHS did not agree with GAO's conclusions that the results of the experiments have not clearly demonstrated that competitive fixed-price contracting will work successfully in Medicare. It said the conclusions placed too much emphasis on the Illinois experiment, were premature, and did not recognize the experience gained from the experimental program. HHS said it learned from the experiences and believes that competitive, other-than-cost, contracting can be executed successfully in Medicare. (See p. 89.)

GAO based its conclusions on the three part B experiments and acknowledges that its concerns about the potential impact of competitive fixed-price contracting in Medicare are heavily influenced by the negative aspects of the Illinois experiment. These negative aspects--poor service to providers and beneficiaries and inaccurate program payments--can overshadow the positive aspects of administrative cost savings. (See p. 82.)

CONTRACTOR COMMENTS AND GAO'S EVALUATION

In commenting on the report, Buffalo Blue Shield's major concerns appeared to be with the description and characterization of its initial months of operations and with the description of its overall performance compared to that in the Maine experiment. (See pp. 99 to 103.)

GAO's conclusions concerning the relative successs of the New York experiment compared with the Maine experiment was based solely on a comparison of the performance results during the first 6 months of implementation. The results show that the initial implementation in Maine went far more smoothly than it did in New York. (See pp. 47 and 48.)

EDSF stated that the report is limited in scope, dwells on history, and reflects selectivity in research and methodology. It identified 23 specific issues for detailed comment and submitted a considerable amount of detailed material in support of its comments.

GAO based its evaluation of all three experimental contractors on the entire contract periods, including the latest data available. Further, GAO used, as the performance measures, the contract standards which all the contractors bid on. (See pp. 68 to 71.) EDSF's comments on the 23 specific issues and GAO's evaluation are contained in appendix V. (See pp. 116 to 152.)

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ABBREVIATIONS

BSM	Blue Shield of Massachusetts
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPEP	Contractor Performance Evaluation Program
CPT-4	Current Procedural Terminology, 4th edition
EDSF	Electronic Data Systems Federal Corporation
GAO	General Accounting Office
HBP	hospital-based physician
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
Maine BC/BS	Maine Blue Cross and Blue Shield
NH-VT BC/BS	New Hampshire-Vermont Blue Cross and Blue Shield
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services
RFP	request for proposal
RRB	Railroad Retirement Board

CHAPTER 1

INTRODUCTION

At the request of the Chairman, Subcommittee on Health, House Committee on Ways and Means, we reviewed the three competitively awarded fixed-price contracting experiments in Medicare as a followup to our June 29, 1979, report to the Congress, "More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing" (HRD-79-76). In that report we expressed some concerns about the potential impact of competitive fixed-price contracting on the Medicare program. We recommended that the Department of Health and Human Services (HHS) thoroughly evaluate the current experimental fixed-price contracts before any significant legislative changes are made in Medicare's contracting provisions.

As requested by the Chairman, our review focused on the performance of the experimental contractor in Illinois--Electronic Data Systems Federal Corporation (EDSF). Since beginning claims processing operations in Illinois on April 1, 1979, EDSF has experienced numerous performance problems resulting in major disruptions of services to beneficiaries and providers, a high degree of inaccuracy in processing and paying claims, and a lack of responsiveness to beneficiary and provider inquiries. We testified on several of these matters before the Subcommittee on April 28, 1980.

We also addressed several allegations made in August 1980 of questionable actions EDSF took during the last 3 months of 1979 to deal with the problem of a large backlog of pending claims and during the first several months of 1980 to dispose of a large backlog of unanswered correspondence. The allegations were discussed in a December 16, 1980, report to the Chairman and Congressman Paul Simon (HRD-81-44 and 45).

MEDICARE AND ITS ADMINISTRATION

Medicare is a Government program which pays much of the health care costs for eligible persons who are generally 65 and over or disabled. The program provides two basic forms of protection:

- --Part A, hospital insurance benefits, generally financed by special social security taxes, which covers inpatient hospital services and certain posthospital care in skilled nursing facilities and patients' homes.
- --Part B, supplementary medical insurance benefits, which is a voluntary program, financed by premiums of enrollees and Federal contributions covering physician services and many other health services.

As of July 1, 1980, about 27.5 million individuals were eligible for part A benefits. Benefit payments for fiscal year 1980 amounted to $23.8 billion; about 96 percent were for inpatient hospital services. About 27.1 million individuals were enrolled for part B benefits as of July 1, 1980. Benefit payments for part B in fiscal year 1980 amounted to $10.1 billion. About 70 percent were for physicians' services; about 20 percent were for outpatient hospital services.

The Secretary of HHS has delegated administration of the Medicare program to the Health Care Financing Administration (HCFA), which is responsible for operating the program, establishing policy, and developing operating guidelines.

HCFA administers part A and part B benefits furnished by institutional providers (e.g., hospitals, skilled nursing facilities, and home health agencies) with assistance from 69 intermediaries. These intermediaries pay health service providers usually on the basis of reasonable costs. Sixty local Blue Cross organizations subcontract with the Blue Cross Association, which has a national prime contract. Eight commercial insurance companies and HCFA's Division of Direct Reimbursement are the remaining intermediaries. In fiscal year 1980 intermediaries spent about $223.9 million for administrative costs and processed about 31.8 million part A and part B bills. Because the vast majority of these payments involve part A benefits, unless otherwise specified we associate intermediaries with the administration of only part A in this report.

HCFA administers part B benefits furnished by noninstitutional providers, such as doctors, laboratories, and suppliers, with the assistance of 42 carriers under prime contracts with the Government. Carriers perform many functions similar to intermediaries; however, their payments are usually based on reasonable charges. Twenty-seven of the carriers are Blue Shield plans, 13 are commercial insurance companies, 1 is principally a data processing firm, and 1 is a State agency. In fiscal year 1980 carriers spent about $398 million in administrative costs and processed about 152.3 million claims.

BACKGROUND ON MEDICARE CONTRACTING

The Medicare legislation and the accompanying committee reports reflected the congressional decision that program administration be carried out by contracting with private organizations that already serve as third-party payers of health care services and that perform in their private business many functions they would perform for Medicare. Because these organizations had to adjust their systems to accommodate Medicare's complex reasonable-charge determinations and strict Government reporting requirements for a new program, the selection of cost reimbursement contracts seemed appropriate.

Title XVIII of the Social Security Act provides that HHS enter into cost reimbursement contracts with carriers and intermediaries which result in neither a profit nor a loss from carrying out Medicare activities. In essence, Federal procurement regulations regarding competitive bidding are waived.

Medicare legislation also intended that a system of local carriers and intermediaries be established that could respond immediately to circumstances where they were already operating and provide maximum personal services to Medicare beneficiaries. The law provided for institutional providers (such as hospitals) to nominate their intermediaries and gave these providers wide choices in selecting intermediaries. It was the Congress' intent that enough carriers would be selected on a geographic basis to promote a competitive performance environment and permit comparisons of individual performance.

Although the congressional intent called for comparisons of contractor performance and costs followed by termination of poor performers, HCFA has taken only limited action in this area. The cost contract and HCFA's failure to terminate poor performers have been criticized for many years. Several reports have been issued addressing the wide variation in performance and costs per claim among the carriers and intermediaries.

This criticism led to the enactment in October 1972 of section 222 of Public Law 92-603, which gave HHS the authority to experiment with incentive reimbursement arrangements and fixed-price contracts to determine whether such arrangements would induce the most effective, efficient, and economical performance.

HCFA has three ongoing experiments in Maine, Illinois, and upstate New York that were intended to test the viability and impact of competitive fixed-price procurement 1/ in part B of Medicare. In December 1978 HCFA completed a 2-year part B incentive contracting experiment with Blue Shield of Maryland. HCFA is also experimenting with fixed-price contracts in part A in New York and Mis-

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1/HHS uses the term "competitive fixed-price procurement" when it refers to competitively negotiated contracts in the Medicare program. Technically, the term encompasses both formal advertised contracts and negotiated competitive contracts. The negotiated competitive contract process does not have the rigid set of formalized procedural steps inherent with formal advertising, and factors other than the lowest price are used in making the contract award. To minimize the technical jargon, in this report competitive fixed-price procurement refers to competitive negotiation, not to formal advertisement.

souri, although the latter was delayed by litigation. The experiment in Maine was recently recompeted and the contract modified to include certain incentive provisions.

PREVIOUS GAO REPORT ON MEDICARE CONTRACTING

Section 12 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), enacted on October 25, 1977, directed us to study the claims processing system under Medicare to determine what modifications should be made to achieve more efficient claims administration.

Specifically, we were asked to determine whether and to what extent more efficient claims administration could be achieved by

--reducing the number of participating intermediaries and carriers,

--making a single organization responsible in particular areas for processing claims under part A and part B of Medicare,

--providing for the performance of claims processing functions based on a prospective fixed price,

--providing incentive payments to the most efficient organizations, or

--other modifications in such structure and related procedures.

In our June 29, 1979, report, we cited many opportunities for HHS to improve its administration of Medicare and recommended a number of actions for the Congress and HHS. We stated that, while competitive fixed-price contracting may well be the ultimate and most desirable goal for modifying Medicare's administrative structure, we believed there was insufficient information to make such a legislative change at that time.

We suggested that a more logical and prudent approach would involve a tripartite strategy featuring

--a careful and objective evaluation of the ongoing experiments in competitive fixed-price contracts to assess their effect on benefit payments and services to providers and beneficiaries,

--further experiments aimed at evaluating (1) whether it was feasible to merge parts A and B under a single contractor and (2) whether incentive contracts will work successfully in the Medicare program, and

--immediate action to reduce the number of contractors in the program by eliminating the less efficient performers.

The next chapter discusses the principal findings and conclusions of the June 1979 report and the actions HHS and the Congress have taken since that time.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this review were to (1) follow up on recommendations made in our June 1979 report, (2) evaluate the performance of the three experimental fixed-price contractors, and (3) relate the results of the experiments to the legislative issue of competitive fixed-price contracting in Medicare. As requested, our major emphasis was on EDSF's performance in Illinois.

To follow up on our prior recommendations, we relied principally on an April 8, 1981, status report by HCFA to the Secretary of HHS describing the actions taken on our June 1979 report. We also discussed the status report with officials from HCFA's Bureau of Program Operations.

For each experiment, we relied principally on the workload data compiled by HCFA and used in its quarterly assessments of each contractor's performance. As discussed on page 21, HCFA's assessments of performance are based on a two-faceted system of workload standards and functional standards. The workload standards are based on regular reporting of monthly workload data to HCFA in such areas as claims processing timeliness and accuracy. We also reviewed the data compiled by HCFA in its monitoring of the functional standards. 1/ These data were obtained largely from the records of the HCFA monitors who worked onsite at the contractors' offices and were evaluating the contractors in several operational areas.

Our overall characterization of contractors' performance as satisfactory or unsatisfactory is based principally on the contractors' performance relative to the standards in each fixed-price contract. The terms--satisfactory or unsatisfactory---are the terms HCFA used in its annual contractor evaluation reports. In these reports, which had not been prepared for the Illinois or New York contractors as of July 1, 1981, performance in several areas is described by HCFA as either satisfactory, adequate but needs improvement, or unsatisfactory.

1/The contractors must comply with all pertinent operational instructions in seven functional areas (see p. 21).

In addition to analyzing various performance data compiled by HCFA for all three contractors, we reviewed the steps taken by HCFA and the contractors during the transition phase of the contracts--the period when the new contractors were transferring records and files from the incumbents and preparing their processing systems to begin operations. Where major processing problems--such as claims and correspondence backlogs--arose after the implementation began, we reviewed the actions taken by HCFA and the contractors to resolve them.

Much of our work had already been done for the Maine contract. In our June 1979 report, we reported on the transition phase and the early months following implementation. The remaining work involved analyzing the more recent performance data supplied by the contractor and HCFA.

In New York we concentrated primarily on reviewing the steps HCFA took to determine that the new contractor had accurately transferred records and files from the previous contractors and that it had properly set up and tested its new data processing system. Most of our work involved reviewing the records and files of these activities at HCFA's offices in New York City and interviewing the HCFA staff who worked with the contractor. We also discussed these transitional efforts with the appropriate managers at the contractor's Medicare offices in Binghamton, New York. Discussions concerning problems with claims and correspondence backlogs were held with the company vice-president in charge of the Medicare operations and with various department heads.

Our work in Illinois was on a much broader scale. Although we began with the same objective as in New York, several circumstances required us to modify our approach. During our review, most of which was performed at EDSF's offices in Des Plaines, Illinois, we received numerous complaints and allegations about the contractor's performance. Because of the seriousness of these problems, we had to shift the focus of our review to address these allegations. The scope of this work was discussed in our December report. Additionally, we could not follow the approach we took in New York of reviewing the step-by-step transitional tasks because of the lack of documentation at HCFA and the contractor in Illinois.

We reviewed certain segments of EDSF's technical proposal and compared them to what was actually done. We also studied EDSF's data processing system. While this did not involve a comprehensive analysis or reliability assessment 1/ of EDSF's computer operations, we did become knowledgable about many aspects of the system. Work was performed in Illinois and at EDSF's corporate headquarters in Dallas, Texas.

1/An evaluation of the accuracy and reliability of computer-processed information, including assessing the adequacy of controls over the processing. Such an evaluation is necessary to quantify the risks of inaccurate information being produced by the computer system.

CHAPTER 2

PROGRESS SINCE GAO'S 1978-79 STUDY OF MEDICARE'S CLAIMS PROCESSING SYSTEM

HHS has taken a number of actions relating to recommendations in our June 29, 1979, report to the Congress. While some of the recommendations required congressional action, there were several we suggested be implemented immediately. For the most part, HHS agreed with our recommendations, stating that they were a major step toward improved Medicare administration. HHS, however, saw a need for broader legislative changes to implement some of our recommendations. In addition, the Department believed it should have full legislative authority to proceed with competitive contracting.

A summary of the matters discussed in our 1979 report and HHS' and the Congress' subsequent actions follows.

FIXED-PRICE PROCUREMENT IS DESIRABLE-- BUT ONLY LIMITED DATA WERE AVAILABLE

Although experiences with competitive fixed-price contracting in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) 1/ and the Medicare program demonstrated that this contracting method could save up to 30 percent of administrative costs, we were not prepared to recommend a broad legislative change from the existing contracting system in Medicare because:

--Administrative costs in Medicare represented only about 3 percent of total program costs, and the effect of such fixed-price procurement on benefit payments had not been determined. Failure to assure adequate controls over benefit payments could more than offset savings in administrative costs.

1/CHAMPUS provides financial assistance for medical care provided by civilian sources to dependents of active duty members, retirees and their dependents, and dependents of deceased members of the uniformed services.

The program is administered by the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), located at Fitzsimons Army Medical Center near Denver, Colorado. OCHAMPUS is under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs).

OCHAMPUS contracts with fiscal agents to process and pay claims under CHAMPUS. These fiscal agents perform generally the same functions carriers and intermediaries perform under Medicare.

--Performance in CHAMPUS had not been good, and many contracts had been terminated or not renewed--resulting in disruption of the program's administration and services.

Since 1976 the Department of Defense had converted all CHAMPUS contracts to competitively awarded contracts on a fixed-rate-per-claim basis. We analyzed 11 fixed-price contracts (covering 20 States) that had been in effect for 1 year. Overall savings in administrative costs were about 20 percent--about $1.2 million for the 20 States analyzed.

The projected savings in the three Medicare experiments were even greater. Based on the contract prices in each of the procurements, we estimated administrative cost savings over the terms of the contracts of approximately $32 million (about 32 percent). However, a number of factors involved in these experiments besides the change in contract type could account for part of the projected savings--such as the consolidation of territories, a reduction in the number of carriers, the elimination of medium- to high-cost carriers, and a change in carrier location to a different employment market.

Only limited data were available on the effects of competitive fixed-price procurement on contractor performance in Medicare. The effects, if any, on the quality of service provided and control over program payments (which accounted for about 97 percent of total program costs) were not yet known. Performance in CHAMPUS had not been good, however. Our review of CHAMPUS competitive procurement showed the following:

--OCHAMPUS officials believed that contractor performance under fixed-price contracts had been adequate at best and in some cases poor.

--OCHAMPUS officials believed that some contractors submitted unrealistic price proposals and were losing money on the contracts.

--Contractors who obtained CHAMPUS contracts and had no prior experience generally had difficulty and left the program or were terminated. Five contracts, involving 15 States, were terminated at the request of the contractor, OCHAMPUS, or by mutual agreement. In all cases, poor performance was indicated.

--CHAMPUS contracts were written for 1 year with two 1-year options. Three experienced CHAMPUS contractors requested that their options not be renewed.

--Changing contractors disrupted services to beneficiaries and providers.

Before a similar broad change in contracting methods was made in Medicare, we believed it should be determined whether (1) performance and services would suffer during and after contractor changeover, (2) the Government would be willing to accept the problems of contractor turnover in exchange for lower administrative costs, (3) past poor performers under cost contracts could significantly lower costs and improve performance under competitive procurement, (4) program payments would be adequately controlled, and (5) the selection process and contract design used in the experiments would be sufficient for assuring a smooth procurement system. The experiments required further evaluation to address these issues.

We recognized that HHS might need a long time to fully evaluate the experiments and determine the effects of competitive fixed-price contracting. Therefore, we suggested that the Congress consider providing HHS with some contingency authority to expedite the implementation of competitive fixed-price contracting should the experiments prove favorable to the Medicare program. We believed the contingency authority should involve authorizing the Secretary of HHS to use competitive fixed-price contracting after fully evaluating the experiments and demonstrating to the Congress' satisfaction that no measureable adverse effects will occur.

ADDITIONAL EXPERIMENTS NEEDED

We recommended experimentation to evaluate the feasibility of a single contractor processing parts A and B workloads using an integrated data processing system. Additional experiments were also recommended to evaluate whether including performance incentives in contracts would work in the Medicare program.

Combining administration of parts A and B

Many organizations perform as both an intermediary and a carrier in Medicare. However, because of a wide variation in workload distributions, parts A and B work are rarely handled by the same contractor in a geographical area.

The functions performed by intermediaries and carriers are quite similar. Therefore, theoretically, combining administration of parts A and B in a single territory should improve the coordination of program benefits for beneficiaries, eliminate some duplicative functions and costs, and reduce additional overhead costs associated with having two or more companies instead of one. However, the available evidence suggested to us that the optimal advantages to be obtained from combining parts A and B would be achieved through an integrated claims processing system.

Although only limited information was available on the cost effectiveness of such an integrated system in Medicare, the probable advantages included some savings in program payments from increased and more effective utilization review activities. Data from both parts can be readily exchanged, and decisions made under one part can be carried over to the other. More complete data on program benefits or medical services rendered can be developed for providers and beneficiaries, resulting in more informed decisions in utilization review. No such system, however, was being used to process parts A and B data in Medicare although, according to several contractors, the capability existed.

We simulated a relatively simple computer edit which matched the dates of service on beneficiaries' part A hospital billings with comparable data on the part B physician claims. The simulation identified several problems that we believed HHS should examine through a demonstration project, in order to obtain the maximum advantages of improved utilization review through an integrated claims processing system.

Incentive contracting

We also expressed the view that the Medicare program should experiment further with incentive contracting on either a cost or fixed-price basis. A system of incentives, designed to reward contractors for improved performance above satisfactory levels and to penalize contractors for performance below those levels, should improve efficiency in the Medicare program.

HCFA had not adequately experimented with incentive contracting. Although an experiment was conducted with Blue Shield of Maryland to test the desirability of incentive contracting in part B, we did not consider this a true incentive contract. It provided little insight into whether incentive contracts will work in the Medicare program. There had been no experiments with incentive contracting in part A.

THERE ARE TOO MANY CARRIERS AND INTERMEDIARIES

While the experiments were being carried out and evaluated, we cited several immediate measures in our June 1979 report which should be taken to reduce the numbers of carriers and intermediaries. One of these measures--implementating performance standards--had been needed in the Medicare program since its inception. HCFA planned to develop such standards by the end of 1980.

With the implementation of standards for part A and B contractors, HCFA needed to establish a firm policy of contract termination for poor or marginally performing contractors. HCFA had identified several contractors over the years--particularly in part B--as being "either chronic poor performers or becoming progressively worse without mitigating circumstances," yet little action had been taken to terminate their contracts. A system of strict contract monitoring and budgetary control, followed by a stong policy of contract termination for poor or marginal performers, could introduce many of the advantages of competition into the current Medicare contract environment and meet the intent of the Congress (see p. 3).

We reported that there were too many carriers and intermediaries administering the Medicare program. Cost studies by several Medicare carriers and intermediaries done at our request indicated that savings of 8 to 39 percent and 5 to 16 percent, respectively, could be realized by consolidating carrier and intermediary workloads and distributing larger workloads to fewer contractors. The savings would be achieved primarily because of the large amount of fixed or semifixed costs that are part of each contractor's operations. The actual amount of these savings was not projected because of the number of alternatives available for distributing the workloads and territories.

The Secretary of HHS was given the authority in 1977 to change the part A administrative structure by assigning and reassigning providers to intermediaries. The authority to change the administrative structure had always been available under part B, yet, despite the Congress' intent regarding carrier selection and several subsequent reports addressing wide variations in carrier costs and performance, HHS had taken little action to change the carrier configuration.

SEPARATE CONTRACT WITH RAILROAD RETIREMENT BOARD IS UNECONOMICAL

We evaluated the role of the Travelers Insurance Company under its contract with the Railroad Retirement Board (RRB) as the nationwide carrier for part B claims from eligible railroad beneficiaries. We estimated that an additional $43 million in administrative costs had been incurred in fiscal years 1970-78 to maintain a separate nationwide carrier to process RRB part B claims.

Maintaining a separate carrier to pay RRB claims has not proven to be the most efficient or economical arrangement. We estimated that legislation to terminate this arrangement could result in yearly administrative cost savings of about $6.6 million--$5.4 million resulting from economies of scale present in the area carriers' larger claims processing operations and $1.2 million from eliminating costs resulting from misrouted RRB claims. 1/

MEDICARE/MEDICAID CROSSOVER CLAIMS SHOULD BE PROCESSED BY AN INTEGRATED SYSTEM

In our June 1979 report we pointed out that administrative costs could be reduced if Medicare contractors also processed through an integrated system the Medicaid 2/ liability for Medicare coinsurance and deductible expenses of individuals eligible for both programs. Provider dissatisfaction would also be lessened because payments would be made more promptly. An integrated system eliminates the double processing of crossover claims 3/ and thereby reduces costs and time delays which occur when separate systems are used.

PREVIOUS RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommended that the Secretary of HHS direct the Administrator of HCFA to

--evaluate the ongoing experimental fixed-price contracts to determine their advantages and disadvantages in Medicare;

--incorporate performance standards in all Medicare contracts;

--implement a firm policy of contract termination for poor or marginally performing contractors;

1/A misrouted claim is a request for payment of an RRB part B claim that has been sent by either an RRB beneficiary or a provider of medical services to an area carrier instead of to Travelers. These claims are generally identified either before processing by the area carrier or are processed completely but with no reimbursement check issued. In either case, costs are incurred to identify, handle, and redirect misrouted claims to Travelers.

2/The Medicaid program, established by title XIX of the Social Security Act, is a grant-in-aid program which became effective January 1, 1966. Under this program the Federal Government shares with the States the costs of providing medical assistance to certain individuals whose incomes and resources are insufficient to pay for health care.

3/Crossover claims are claims for which Medicare makes the primary payment for the service and the Medicaid program pays the Medicare coinsurance and deductible amounts.

--conduct experiments to evaluate the feasibility of merging parts A and B under a single contractor, and the effectiveness of requiring an integrated software system approach throughout the program; and

--conduct additional experiments, including cost and performance incentives, to evaluate whether incentive contracting will work successfully in the Medicare program.

We also said the Secretary should immediately reduce the number of carriers and intermediaries participating in the Medicare program. To determine which contractors should be eliminated, we recommended that the Secretary direct the HCFA Administrator to determine the most efficient configuration of Medicare workloads and territories by

--identifying the carriers and intermediaries that are the most efficient with their existing workloads and

--identifying, through analyses of carriers' and intermediaries' costs, the carriers and intermediaries that can most efficiently handle larger workloads.

The Secretary should then terminate the contracts with the least efficient carriers and intermediaries and, as an interim step, while experimenting with competitive fixed-price and incentive contracting, award new contracts on a cost reimbursement basis.

PREVIOUS RECOMMENDATIONS TO THE CONGRESS

We recommended that the Congress:

--Enact legislation to terminate the authority of the Railroad Retirement Board to select a nationwide carrier for Railroad Retirement Board part B claims and to turn over responsibility for processing and paying such claims to the area carriers paying part B claims for all other Medicare beneficiaries.

--Amend title XIX of the Social Security Act to require that the Medicaid liability for crossover claims be processed by the Medicare contractors using integrated data processing systems, unless the individual States can demonstrate to the Secretary of HHS that another arrangement is as efficient and effective.

SUBSEQUENT ACTIONS BY HHS AND THE CONGRESS

HHS has taken a number of actions relating to those recommendations. Performance standards have been issued for part A and part B contractors. Some contracts have been terminated, and certain territories and workloads have been consolidated. Also, there has been additional experimentation with incentive contracting.

Evaluation of ongoing experimental contracts

HCFA awarded a contract in September 1981 for an independent evaluation of the experimental contracts in Maine, Illinois, and upstate New York. The scope of work covers all phases of the contract procurements, beginning with the preparation of the request for proposals (RFP) through the transition, implementation, and operational phases. The evaluation is to address the contractors' costs and the related impact on program payments and beneficiary services.

HCFA's planned scope of work is much broader and more complex than the scope of our review of the experiments. In the evaluation HCFA plans to answer such questions as:

1. In what ways did the nature of HCFA's involvement in the carriers' operations change from that present under a cost contract?
2. What impact did the contracts' "risk provisions" have on carrier performance and costs?
3. What impact did claims payment delays, inaccurate payments, inappropriate correspondence responses, and delays in handling of appeals have on beneficiaries and providers?
4. What was the full administrative cost to HCFA for developing the RFPs, reviewing proposals, helping to implement each experiment, and adjusting for levying and collecting performance penalties and was there an increase or decrease in HCFA monitoring and service costs?

The administration has proposed legislation (see p. 17) to authorize competitive fixed-price contracting before this study has been undertaken and the results known. Such legislation would be inconsistent with our previous recommendation that HHS thoroughly evaluate the experimental fixed-price contracts before any significant legislative changes are made in Medicare contracting.

Performance standards have been issued

Specific performance standards are a part of each fixed-price contract. Such standards also have been developed and are used in evaluating all part A and part B cost reimbursement contractors. The part A evaluation program was implemented October 1, 1979; the part B program, a year later.

After these evaluation programs have been in existence for several years and the contractors are familiar with the process, HCFA plans to consider incorporating the standards and criteria in the cost contracts.

Reduction in the number of carriers and intermediaries

A number of changes made in the contracting configuration have resulted in fewer Medicare carriers and intermediaries and some savings in administrative costs.

The Blue Cross Association and HCFA have initiated several consolidations in part A. The workloads of seven Blue Cross plans in New York have been consolidated, and only one plan now has a subcontract with Medicare. Additionally, the Association is consolidating some of the intermediary workloads in West Virginia and Pennsylvania.

HCFA has also announced the nonrenewal of several contracts--three in part B and one in part A. In part B, HCFA transferred the workloads of three part B carriers--Milwaukee Blue Shield, Delaware Blue Shield, and District of Columbia Blue Shield--to two other existing carriers. The workload of a Blue Cross plan in Memphis, Tennessee, was also transferred to another plan after HCFA decided not to renew the part A subcontract.

Another consolidation resulted from the voluntary withdrawal from the program of South Dakota Blue Shield. This part B carrier's territory and workload were assigned to North Dakota Blue Shield, which now handles both States.

HCFA is also proceeding with a part A experiment in Missouri which had been delayed by litigation for almost 2 years. This experiment places all part A services in Missouri under one contractor. Previously, five intermediaries serviced providers in that State.

Additional experiments with incentive contracting

HCFA has two experiments underway with incentive contracting. The part A contract in New York, where the number of Blue Cross plans serving as intermediaries was reduced from seven to one, is a negotiated fixed-price experimental contract containing provisions for both liquidated damages for poor performance and incentive payments if performance standards are exceeded.

Also, following the recompetition of the part B contract for Maine (see p. 18), a contract was awarded containing provisions for both liquidated damages and incentives which are directly linked to the newly implemented part B performance standards.

Efforts to combine parts A and B under a single contractor

HCFA is testing the advantages of integrated part A and part B computer software systems by allowing a limited number of contractors to procure such systems and to participate with HCFA in evaluating the results.

After developing and implementing a plan for combining parts A and B under a single contractor, HHS was enjoined from completing the experimental contract procurement in Colorado, Wyoming, and Utah by a Federal district court decision. HHS is appealing this decision.

Administration's legislative proposal would change contracting authority

The administration's proposal to amend titles XVIII and XIX of the Social Security Act (introduced on May 28, 1981, as H.R. 3725) includes provisions to terminate RRB's authority to select a nationwide carrier, and to subject all Medicare contracts to competitive bidding requirements. The competitive bidding would be phased in over a 5-year period. There have been no bills introduced in the Congress since our report was issued to deal with the integrated processing of crossover claims.

HHS COMMENTS

Commenting on our draft report (see app. III), HHS stated that we did not give sufficient attention to the fact that it had vigorously pursued the recommendations in our June 1979 report. HHS' major concern appeared to be with our characterization in the draft report of its efforts as "some progress." Some wording changes were made to the report to more accurately reflect the progress that has been made.

HHS further pointed out that the goal of its experimental contracting program is to create an operating framework which is more conducive to improving the quality of service to providers and beneficiaries at reduced cost to the Government. It stated that its contracting initiatives encompass all of the elements of the "tripartite strategy" recommended in our 1979 report and referenced on page 4 of this report.

CHAPTER 3

THE MAINE EXPERIMENT--SATISFACTORY PERFORMANCE WITH LITTLE ADMINISTRATIVE COST SAVINGS

Blue Shield of Massachusetts (BSM) has completed the final year of its fixed-price contract to process Medicare part B claims in Maine. The contract was originally for a 39-month period and, following renegotiations, was extended for another year. The 39-month contract, estimated to have saved about $341,000 in administrative costs, was the first of three ongoing experiments to test competitive fixed-price procurement for Medicare part B. HCFA recently recompeted this contract and a new award was made to BSM on June 1, 1981. The new contract began on October 1, 1981.

BSM performance under this contract has been satisfactory and better than its performance under a traditional cost reimbursement contract to process part B claims in Massachusetts. HCFA and Blue Shield officials told us that the higher performance has resulted from the fixed-price nature of the contract with its associated performance penalties, which has mandated closer management attention and the commitment of BSM's more experienced staff.

In our June 29, 1979, report to the Congress on Medicare fixed-price contracting, we stated that the experiment's early results were favorable, but we cautioned that this experiment might not be representative of what might happen in other fixed-price contracts in Medicare. Our caution was based on several factors: the contract involved a relatively small claims volume, it was taken over by an experienced carrier already processing a much larger workload, and the estimated unit price 1/ of the winning bid was much higher than the other experiments. In addition, Blue Shield and HCFA took special steps to minimize the potential adverse effects of the experiment. These steps consisted mainly of a "consistency approach" that was applied throughout the contractor transition, whereby BSM adopted many of the system features of the previous carrier.

We believe that the consistency approach was one of the major factors in this experiment's success, particularly in minimizing the disruption of services to beneficiaries and providers. Other major contributing factors were the experience of Blue Shield management and clerical staff and the fact that the contract price

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1/In all three part B experiments, contractors were not required to include claim volume projections in their proposals. The unit prices were estimated based on the contractors' total price divided by HCFA's estimate of the total claims volume.

(the price BSM agreed to operate for) did not represent a significant change from the costs at which BSM was operating in Massachusetts. Thus, the incentives to reduce staff or cut services were minimized.

CONTRACTOR SELECTION

The initial experiment arose when Union Mutual Life Insurance Company decided to terminate its contract as the Medicare part B carrier for Maine. The company's decision was based on a desire to concentrate its resources in its private lines of business. Union Mutual's administrative costs were high compared to other part B carriers, and the carrier felt that without incentives the Medicare program offered little potential for profit. Maine provided an excellent opportunity for an experiment because Union Mutual withdrew voluntarily and had one of the smallest carrier workloads, with 542,495 claims processed in fiscal year 1977.

The RFP for the experimental contract was issued on March 18, 1977. Bidders were requested to submit a total firm fixed price for all carrier services for a 39-month period, consisting of a 5-month transition period beginning July 1, 1977, and 34 months of claims processing beginning December 1, 1977.

The RFP stated that the final price would be renegotiated only if legislative changes or other action substantially changed the scope of work. While HCFA officials recognized that this could result in contractors including contingency factors in bids, resulting in higher prices, they believed it was preferable to have contractors absorb the cost of minor administrative or procedural changes.

The RFP provided that the bidder was responsible for estimating claims volume during the contract period and that there would not be any price adjustment for volume. HCFA was concerned that a contractor could manipulate the claims count by inducing more frequent claim filings from physicians or beneficiaries.

HCFA developed a detailed plan for contractor selection in which each proposal was evaluated on the basis of company experience, the quality of the technical proposal, and price. Weights were assigned as follows: company experience, 30 percent; technical proposal, 30 percent; and price, 40 percent. Five organizations submitted proposals--Aetna Life Insurance Company, Prudential Insurance Company, BSM, Maine Blue Cross and Blue Shield (Maine BC/BS), and New Hampshire-Vermont Blue Cross and Blue Shield (NH-VT BC/BS). Although NH-VT BC/BS was the low bidder by a substantial margin, BSM placed first overall in the scoring:

Bidder	Total (note a)	Point difference from winning bidder
BSM	863.21	-
NH-VT BC/BS	848.81	14.40
Prudential	815.83	47.38
Maine BC/BS	782.90	80.31
Aetna	645.03	218.18

a/Total points possible--1,000.

BSM's winning margin was gained by the experience factor.

The price offers submitted by the contractors in May 1977 compared favorably with national average unit costs and Union Mutual's unit cost experience. Union Mutual's unit costs for fiscal years 1976 and 1975 had been $3.74 and $3.58, respectively, while national average unit costs had been $3.19 and $3.11. The following table shows HCFA's estimate of unit price per bid for the Maine contract, based on a HCFA projection of the claims volume for the entire contract period.

Bidder	Total price	Estimated unit price for contract
NH-VT BC/BS	$4,737,498	$2.59
BSM	5,285,000	2.88
Prudential	5,450,000	2.98
Maine BC/BS	5,660,700	3.09
Aetna	8,496,100	4.46

To compare total prices, HCFA used an estimated total price of $5,626,400, based on the estimated claims volume multiplied by the national average unit cost of $3 per claim. This estimate shows a savings from the competitive bidding:

Bidder	Total price	Estimated savings
Prudential	$5,450,000	$176,400
BSM	5,285,000	341,400
NH-VT BC/BS	4,737,498	888,902

As stated above, this analysis is based on HCFA's volume projection. Contractors were responsible for estimating claims volume, but they were not required to include their projection in the proposals. Any variance between HCFA and contractor volume projections would cause price comparisons to be inaccurate. For example, if a contractor estimated that the claims volume was greater than HCFA's projection, then what is shown as estimated unit price would be overstated.

PERFORMANCE IS SATISFACTORY

After an initial period of generally unacceptable performance, BSM's performance in Maine exceeded contract standards and is considered satisfactory for the areas where comparable data are kept on other carriers. For the 13 evaluation periods (calendar quarters) ended June 30, 1981, BSM has passed 147 of the 156 standards evaluated.

Performance monitoring system

HCFA implemented a more sophisticated performance monitoring system in the experiments than it had for its cost contracts. Acceptable contractor performance under the cost reimbursable contracts had never been defined by specific standards; most contractor evaluations were based on a system of goals established by each HCFA regional office, and most of the regional office evaluation systems were based largely on the judgment of HCFA representatives who worked at the contractors' facilities.

Because of the fixed-price nature of the experiments and the concern that this type of contract would lead to reduced service, HCFA devised a monitoring plan to quantify performance as much as possible and allow for liquidated damages to be assessed for performance deficiencies.

The monitoring plan for the Maine experiment (as well as Illinois and New York) imposed two quality control systems on the contractor. The first--System One--uses five performance standards based on quantified workload data, some of which had been previously collected by HCFA. The second--System Two--is based on continuous reviews and determinations of the contractor's compliance with all pertinent operational instructions in seven functional areas. 1/

In addition, all the experimental contracts include provisions for monetary penalties for deficient performance. The penalties are to be assessed for any standards missed in a 3-month period. The penalties range from $10,570 per standard in Maine to $52,250 per standard in Illinois.

Most contract standards have been met

Although BSM began claims processing on December 1, 1977, HCFA's monitoring plan did not become effective until the quarter that began April 1, 1978. For the 13 evaluation periods (quarters)

1/Claims processing, coverage and utilization safeguards, program reimbursement, computer operations, beneficiary services and professional relations, program integrity, and quality assurance.

ended June 30, 1981, BSM has passed 147 of the 156 standards evaluated. The nine failed standards were all in System One and related to claims processing errors detected through the quality assurance program.

The quality assurance program developed by HCFA and used by all part B carriers systematically reviews a sample of claims drawn from those processed to completion by the carrier during a given reporting period. The review identifies various types of processing errors, including those affecting reimbursements. The results of the review are included in a report designed to provide a basis for evaluating and comparing carrier performance. HCFA's regional office personnel validate the carrier's results by subsampling about 10 percent of the carrier's sampled claims.

Two error rates are reported--the occurrence error rate 1/ and the payment/deductible error rate. 2/ These rates are computed by a formula which considers the errors found by the carrier and by the HCFA quality review staff. The errors found by HCFA are given more weight in the formula.

There is a contract standard for each error rate. The contract requires that BSM's occurrence error rate and payment/deductible error rate each be less than those of 60 percent of all other carriers each quarter. BSM's error rates for each quarter since the contract started and the contract standards are shown in the following table. The payment/deductible error rate is very important because it reflects the accuracy of the carrier's benefit payments. The estimated total payment/deductible error 3/ is also shown for each quarter.

1/The estimated number of errors made in the processing of claims for every 100 claim line items in the universe of claims processed in the reporting period.

2/The estimated amount of payment/deductible dollar errors for every $100 of submitted charges in the universe of claims processed. Payment/deductible dollar errors include actual dollar amounts paid in error, actual dollar amounts not paid which should have been paid, and dollar amounts misapplied (either over or under) to the deductible.

3/The statistical estimate of the total of all combined payment and deductible errors, in favor of claimants, in favor of the Government, or combined, in the file of processed claims from which the samples are drawn.

Quarter ended	Occurrence error rate		Payment/deductible error rate		Total estimated payment/deductible error
	BSM	Contract standard	BSM	Contract standard	BSM
					(millions)
Mar. 1978	9.6	(a)	2.3	(a)	$0.3
June 1978	7.1	7.2	1.6	1.8	.2
Sept. 1978	6.0	7.7	1.3	1.8	.1
Dec. 1978	6.5	11.9	1.7	2.8	.2
Mar. 1979	b/9.3	8.2	b/2.7	1.9	.3
June 1979	6.9	7.9	b/2.0	1.7	.2
Sept. 1979	7.3	7.7	2.1	2.1	.3
Dec. 1979	6.3	8.1	1.9	2.0	.3
Mar. 1980	8.0	8.3	b/2.3	2.0	.4
June 1980	b/9.4	7.1	b/1.9	1.8	.3
Sept. 1980	7.2	7.5	2.0	2.0	.3
Dec. 1980	b/10.3	7.2	1.3	1.6	.2
Mar. 1981	b/10.8	7.0	1.5	1.7	.3
June 1981	b/7.1	6.5	1.4	1.6	.3

a/ Contract standards did not apply until the quarter ended June 30, 1978.

b/ Standard not met.

The carrier has failed five standards under System Two of the monitoring plan; however, the problems were corrected during a grace period allowed under the contract, and no penalties were assessed.

BSM performance less satisfactory under its cost contract

BSM's performance under the Maine contract has generally been better than its performance under its cost reimbursable contract to process part B claims in Massachusetts. We applied the Maine

System One standards to BSM's Massachusetts performance data. From April 1, 1978, through June 30, 1981, BSM would have failed 36 of the 65 standards in Massachusetts, while failing only 9 in Maine.

When performance standards were implemented for the Maine contract, standards did not exist for cost contracts. In fiscal year 1979 HCFA regional officials notified all Region I carriers that their performance would be measured against the standards used in the Maine contract; however, these standards are not part of the cost contract and penalties cannot be applied.

HCFA officials believe that performance is much better under the Maine contract because of the performance penalties associated with the fixed-price contract. BSM management has the incentive to pay more attention to the Maine contract and to assign the best staff available. The regional Medicare director believes the greatest advantage of the fixed-price contract is that penalties can be included.

A BSM official stated that more management attention is given to the Maine contract, principally because of the performance penalties. He also added the following reasons for the better performance:

--BSM expended more funds on a per claim basis on the Maine contract, as reflected in the fiscal years 1979 and 1980 final administrative cost reports. BSM's fiscal year 1979 cost reports reflect a unit cost of $2.90 for Maine and $2.55 for Massachusetts. The fiscal year 1980 cost reports reflect a unit cost of $3.07 for Maine and $2.36 for Massachusetts.

--Although the Maine contract standards were used as a performance measure for all Region I cost contractors, HCFA did not allow BSM to adjust its budget for Massachusetts to reflect the increased performance requirements.

--BSM's urban location in Boston has contributed to a high staff turnover rate and the resulting inability to staff both contracts with quality personnel. This adversely affected carrier performance in Massachusetts.

BSM REPORTEDLY LOST MONEY ON MAINE CONTRACT

BSM received $5,221,580 in payments during the original 39-month fixed-price contract. 1/ This amount includes any costs associated with implementation during the initial 5 months of the contract (before actual claims processing), but does not include reimbursement for the 1-year contract extension.

During fiscal years 1978, 1979, and 1980, BSM received $5,063,030 in payments. During this period BSM processed 2,038,070 claims, for an average unit price of $2.48 per claim. For the same period BSM reported $5,998,467 in unaudited actual costs, resulting in an average unit cost of $2.94 per claim. Thus, BSM's reported costs have exceeded contract payments by $935,437.

Drawing conclusions regarding the true financial impact of the Maine contract is difficult without a comprehensive audit of BSM's costs. Such an audit was not part of our review, but is planned by HHS. 2/

CONTRACT EXTENSION

HCFA and BSM began negotiations in May 1979 for a 1-year extension of the contract. BSM first submitted an offer of $2,932,935, based on an estimated claims volume of 1,012,633 and a unit price of $2.90 per claim.

HCFA officials rejected the offer because they estimated the claims volume to be about 866,000 to 909,000. After several months of negotiation, HCFA accepted BSM's fourth offer of $2,140,227, based on a claims volume of 921,000 and a unit price of $2.32 a claim. According to HCFA officials, they decided to accept this offer largely because the price was only 2.2 percent higher than BSM's reported costs of $2,094,757 for fiscal year 1979.

According to BSM officials, they dropped the price to the lowest possible level because of HCFA's stated intent to regionalize claims processing--consolidate all contractors in the region and award a single contract. They told us the price agreed to did not include any provisions for penalties, return on investment, or contingencies. Further, they stated that overhead costs normally charged to the Maine contract were not included.

1/Original contract price reduced for liquidated damages applicable through fiscal year 1980.

2/The last HHS audit of BSM was for the period July 1, 1977, through September 30, 1978.

The estimated claims volume of 921,000 may still be too high. After completing negotiations with BSM, HCFA prepared a further analysis of claims volume, which concluded that BSM's estimate was too high. Using two different statistical methods, HCFA estimated the volume to be either 842,200 or 843,600 claims. These estimates equate to unit prices of $2.53 and $2.54, respectively--nearly the same unit price of $2.48 paid for fiscal years 1978, 1979, and 1980.

"CONSISTENCY APPROACH" TO CONTRACTOR CHANGE MINIMIZED PROBLEMS

In our June 1979 report to the Congress, we stated that problems encountered in contractor turnover may affect the success of competitive procurement. As a new contractor takes over an area, startup problems may result in a period of lower performance and service. Many complaints regarding differences in reimbursement levels may also result because of problems in physician profile conversions, changing procedure coding systems, and differences in how contractors apply program guidelines.

These concerns were also cited by a HCFA steering group [1] in its October 1978 report to the HCFA Administrator. The group pointed out that, in the transfer of carrier jurisdictions, it may take a year before the beneficiary population and medical community adjust to the transfer. Each carrier has unique systems and procedures to handle local conditions, and conversion to a new system is a major problem for the incoming carrier to overcome.

The changeover of the Medicare part B contract in Maine appears to have gone well, especially compared to the other experiments, particularly Illinois. A principal reason problems did not surface in Maine, as they did in the other experiments, was HCFA's attempts to follow a "consistency approach"--requiring BSM to adopt many features of the previous carrier's operations. In addition, problems encountered by BSM in converting the previous carrier's procedure coding system [2] resulted in retention of the previous system and avoided many potential problems, such as changes in payment levels.

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[1] A steering group of high-level officials appointed to examine the methods in selecting, monitoring, and reimbursing contractors for the Medicare and Medicaid programs. The group's final report was issued on October 31, 1978.

[2] Procedure coding and related terminology systems are used by carriers and health insurance companies to provide physicians and third-party payors with a common language to accurately describe the type of service provided and to serve as a basis for medical coverage and payment determinations. The use of approved systems not only varies with carriers, but the compatibility among carriers using the same system may vary, depending on the extent to which a carrier modifies a system for internal use.

Identification of unique features

The Maine contract allowed for a 5-month transition period to facilitate the transfer of carrier functions. During this period, representatives of BSM, Union Mutual, and HCFA met numerous times to discuss the status of various tasks. Early in the transition the representatives developed a list of critical issues that would require the most monitoring. One such issue was to identify all of the things that Union Mutual did differently than BSM did in its Massachusetts operation and to decide how BSM would handle these things in Maine.

HCFA recognized that any differences in procedures or processing routines might produce different payment results and hence adversely affect beneficiary and provider relations in Maine. HCFA's approach to processing differences was that BSM would generally adopt the unique Union Mutual features to assure a smooth transition.

HCFA's Boston Regional Office developed a formal system to identify processing differences and identified 40 BSM system procedures that differed from those used by Union Mutual. These procedures covered a wide variety of items, such as pricing provisions, coverage issues for specific providers, and postpayment review.

The effect of this consistency approach was cited by the regional Medicare director's evaluation of the Maine transition process.

> "The bottom line objectives of the transition process, of course, were to assure that the old carrier's operations were phased out smoothly and that the new carrier could begin to process claims as scheduled on December 1. These objectives were met. UM [Union Mutual] transferred to the new carrier almost the exact number of claims we had projected at the beginning of the implementation. BSM began inputting new Maine claims on schedule on November 11, submitted its first Maine queries on schedule on December 1, mailed the checks from its first weekly summary check run by December 9, was down to 1.2 weeks work on hand in the Maine operation by December 31, and processed 75% of its Maine claims within 15 days in January. Only 2 Congressional inquiries on behalf of constituents regarding the carrier changeover were received, and these were both minor and did not reflect on BSM's performance. Thus, based on these factors, the transition was a success.

> "Another major objective of the transition which we increasingly articulated as the implementation period progressed was that the continuity of service and benefit payments between old and new carriers should be maximized. Hence all of our emphasis on identifying 'unique Maine features' for incorporation wherever appropriate into the new carrier's system. * * * generally we believe this objective was met."

Importance of procedure coding system

In previous work regarding contractor changes, we found that converting the procedure coding system is one of the most critical and difficult tasks to be completed during transition. The HCFA Maine transition committee also identified the conversion as a critical issue. According to the regional Medicare director, this aspect of the conversion was critical because it had the potential for changing the amount of reimbursement doctors would receive and possibly creating an outcry in the Maine medical community.

In its technical proposal, BSM had indicated that the procedure coding system used in Massachusetts would be used in Maine instead of Union Mutual's system. The potential benefits of such a conversion were the ability to establish a fully integrated claims operation for Massachusetts and Maine and to realize substantial economies of scale by having staff able to process claims from either State.

Converting the coding system, however, proved more difficult than anticipated. A larger than planned number of procedures used by BSM in Massachusetts had no match 1/ in the Union Mutual system. This meant BSM would have to find some way to determine the reasonable charge for BSM procedures where there was no such data in Maine. After considering the problems this would involve, BSM officials informed HCFA they could not complete the conversion before the end of the transition period. As a result, the carrier was forced to essentially retain the Union Mutual coding structure.

The potential effects of the procedure coding conversion had it been made are reflected in the following excerpts from the regional Medicare director's evaluation of the Maine transition.

> "* * * even if enough analysis and preparation had been undertaken at an early enough point by BSM to allow this to be accomplished by December 1,

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1/Listing the various procedure codes in each system and arranging them so similarities or matches are identified is often referred to by HCFA and the carriers as "mapping."

> there would inevitably be differences in payment levels which Maine providers would experience after new codes went into effect, and this would complicate the transition and jeopardize acceptance of the new carrier * * *"
>
> "* * * In future transitions, if the procedure coding system used by the outgoing carrier is not to be retained by the new carrier, the task of procedure code conversion should be viewed as one of the most critical early tasks on which the rest of the implementation hangs."
>
> "* * * until the procedure code mapping table had been completed, the carrier could not develop test files for testing purposes * * *"

These potential problems, which were avoided in Maine, are paralleled by actual problems in Illinois, which are discussed in chapter 5.

While BSM's retention of the Union Mutual coding system appears to have eliminated many potential problems, this retention reduced BSM's ability to have a fully integrated claims processing operation for Massachusetts and Maine and greatly limited opportunities to economize. Because of the separate coding systems, BSM maintains basically separate processing systems for its Maine and Massachusetts contracts. Although some supervision is integrated for both contracts, there is no integration of most staff.

In the two largest units of the Maine operation--claims examination/data entry and communications--there is total separation from the Massachusetts operation in terms of both physical location and supervision. In other departments, such as quality control and suspense, there are separate staff with the same supervisor. BSM also maintains separate training materials and personnel for each contract.

CONCLUSIONS

BSM's performance under its fixed-price contract to process Medicare part B claims in Maine has been satisfactory. The performance standards and related penalties associated with the fixed-price contract act as an incentive to perform effectively. These standards and penalties were not in the cost contracts.

The experiment has indicated that, even if a contract is not regularly competed, the threat of competition acts as an incentive for a contractor to lower costs. Despite the fact that BSM's financial reports indicate it is incurring a loss on the contract, it substantially lowered its initial price proposal during negotiations to retain the Maine contract for the option year.

Although the Maine transition went well, this was largely because BSM kept many of the previous carrier's system features. Keeping these features helped to maintain consistency in payments to providers and eliminated potential problems arising from an entirely new system. Because of the consistency approach, however, BSM was required to maintain basically separate staff and was not able to benefit from the economies of scale that could be realized from having the same system for both Maine and Massachusetts.

CARRIER COMMENTS

When given an opportunity to comment, Massachusetts Blue Shield said it was satisfied with the draft report and had no comments to make.

CHAPTER 4

THE NEW YORK EXPERIMENT--AFTER A SHAKY START, PERFORMANCE IS SATISFACTORY

Blue Shield of Western New York (Buffalo Blue Shield) is in the third year of its experimental fixed-price contract to process part B claims for upstate New York. Actual claims processing under the contract began on June 1, 1979, and is scheduled to continue through September 30, 1982.

The experiment is progressing smoothly after some initial performance problems. The transition phase of the experiment was completed successfully, and Buffalo Blue Shield was able to meet its scheduled startup dates for processing claims from the prior carriers despite delays in some transitional tasks. Buffalo Blue Shield encountered difficulties, however, when it began processing claims, resulting in large backlogs of claims and correspondence, and high clerical error rates.

Some of these initial problems were attributable to a change in reimbursement policy initiated by HCFA at the beginning of the contract. This change resulted in a "roll-back" situation, where certain providers or their patients received less reimbursement than they had before. Buffalo Blue Shield was able to straighten out these initial problems, and HCFA now considers the carrier an above-average performer.

CONTRACTOR SELECTION

A contract was awarded to Buffalo Blue Shield on November 1, 1978. This experiment consolidated three carrier territories in upstate New York into one. The contract was offered through a fixed-price competitive process.

The area was previously serviced by Buffalo Blue Shield, Genessee Valley Medical Care (Rochester Blue Shield), and Metropolitan Life Insurance Company. The total part B claims volume for the carrier areas in fiscal year 1978 was 2,692,181, with individual carrier workloads and cost per claim as follows:

Carrier	Claims volume	Cost per claim
Metropolitan	1,663,679	$2.70
Buffalo	663,466	3.71
Rochester	365,036	3.50

The contract is for a 47-month period; transition began on November 1, 1978. Claims processing under the fixed-price contract began on June 1, 1979, in the area Buffalo Blue Shield previously serviced, with the remaining two areas absorbed at 2-month intervals until the territory was fully operational on October 1, 1979. Processing will continue through September 30, 1982.

Price adjustments were only to be allowed in case of major legislative changes or changes in postage or Social Security taxes announced after the price proposals were submitted.

Proposals for the New York experiment were received from six organizations operating as Medicare carriers, including two of the three incumbents. They were Buffalo Blue Shield, Continental Insurance Company, Group Health Incorporated, Metropolitan, Prudential, and the Occidental Life Insurance Company.

The award factors were the same as those used in the other experiments; however, adjustments were made in the weights for technical (15 percent), experience (35 percent), and price (50 percent). The evaluation of proposals resulted in these point awards:

Bidder	Points (note a)	Point difference from winning bidder
Buffalo	908.96	-
Continental	896.29	12.67
Metropolitan	873.98	34.98
Group Health	837.37	71.59
Occidental	822.60	86.36
Prudential	790.55	118.41

a/Total points possible--1,000.

Buffalo Blue Shield, which finished third in scoring in the technical category and fourth in experience, 1/ was able to overcome the other carriers with its 45-point winning margin in the price category.

1/Buffalo Blue Shield stated, in commenting on our report (see p. 101), that someone not thoroughly familiar with HCFA's evaluation methodology might conclude from this ranking that Buffalo lacked the experience necessary to administer Medicare in upstate New York. Blue Shield stated that its experience was equal to or superior to that of all other bidders in its claims processing accuracy and timeliness. Although Buffalo Blue Shield may not have agreed with HCFA's evaluation of the proposals, nevertheless it finished fourth in the experience category.

This experiment received more response than the others in terms of the number of bidders and the competitiveness of price. The following table shows the actual bids and the effective unit price per claim based on HCFA's projected claims volume of 13,270,000.

Bidder	Total price	Estimated unit cost
Buffalo	$20,296,150	$1.53
Group Health	21,358,800	1.61
Continental	22,320,000	1.68
Occidental	23,790,000	1.79
Metropolitan	23,871,000	1.80
Prudential	29,377,000	2.22

We estimated in our June 1979 report that the previous carriers would have incurred about $31.1 million in costs over the contract's operational period. In terms of total price, the successful bid saved an estimated $10.8 million in administrative costs. It is not clear, however, how much of the savings is due to competitive pressures or to other factors, such as consolidated workloads.

THE TRANSITION PERIOD WENT SMOOTHLY

The transition phase of Buffalo Blue Shield's takeover of the upstate New York area went smoothly despite some delays in a number of tasks. Buffalo Blue Shield completed most of its tasks on time and was ready to start processing claims on June 1, 1979. During the period HCFA reviewed Buffalo Blue Shield's progress, tested pertinent files and the computer system, and compared processing results between Buffalo Blue Shield and the outgoing contractors.

Buffalo Blue Shield's major efforts during the transition period

The transition from three carriers to one required Buffalo Blue Shield to accomplish many tasks. The carrier was awarded the contract on November 1, 1978, and was required to be operational by June 1, 1979. On that date it began processing claims from its prior service area. Two months later, on August 1, 1979, Buffalo Blue Shield started processing claims from the Metropolitan area, and finally on October 1, 1979, it completed the transition and began receiving claims from Rochester Blue Shield's service area.

Buffalo Blue Shield prepared a detailed list of tasks to be completed during the transition. Most of them were completed on time, and those that were not did not delay the June 1, 1979, startup date. Generally, carrier officials believe the transition period went smoothly. Some of their major efforts and problems during the transition are described below.

Site selection was based mainly on lower labor cost

The carrier located its new Medicare offices in Binghamton, New York, primarily because the wage rates in the area were lower than those in Buffalo--its home office site and prior location for processing Medicare claims as a cost reimbursement carrier. Also, the workers in Binghamton were not unionized as they were in Buffalo, and Binghamton was more centrally located in the upstate area than Buffalo.

Recruitment was aided by New York State

The carrier worked closely with the New York State Employment Office to recruit and hire personnel for its Binghamton Medicare office. The State Employment Office provided applicant screening, testing, and referral. In addition, it helped develop position descriptions and provided recruiting space to carrier personnel before they were able to move into their new offices. Management personnel were obtained mainly through personal contacts and transfers from Buffalo.

The first group of employees was hired in February and March 1979 so they would be ready for the June 1 startup date. Two other groups were hired to be prepared for the takeover of the other areas in August and October.

Procedure code matching was difficult

Converting procedure codes used by Buffalo Blue Shield, Metropolitan, and Rochester Blue Shield into the carrier's new system was difficult, and it delayed certain transitional tasks. HCFA officials, however, told us these delays did not affect the contractor's ability to begin claims processing on time.

The carrier was able to convert its prior system in Buffalo to its new one with few problems since the two systems were similar. The Metropolitan and Rochester Blue Shield coding systems were different, however, requiring an examination of descriptions to determine matches. Exact matches were easily converted, but where the descriptions were not exact matches or where comparable procedures could not be found on Buffalo Blue Shield's codes, carrier personnel made subjective decisions to match procedures. HCFA reviewed these decisions, and any differences were resolved with the carrier before processing claims in the new service areas.

File conversions were completed with only minor problems

The task of transferring files--computer tapes and hard-copy records--from Metropolitan and Rochester Blue Shield to Buffalo

Blue Shield started shortly after the carrier was awarded the contract. Buffalo Blue Shield sent a team of managers to the other carriers to develop a new list of inventoried files using the list in the RFP as a starting point.

Many files required conversion from the format used by the prior carriers to that used by Buffalo Blue Shield's new computer system. The major files requiring conversion were the claims history, pending claims, prevailing charge, provider, and master pricing files. These files were converted by computer. Other files critical to the claims processing operations had to be developed manually. These included laboratory certification, durable medical equipment, and hospital-based physician (HBP) files. Although problems arose in some areas of conversion, as discussed on page 43, carrier officials told us that overall the file conversions went rather smoothly.

Most files were tested

Once converted, most of the files were tested through a model office test 1/ plan set up by Buffalo Blue Shield's data processing subcontractor--EDSF. 2/ According to an EDSF representative, the computer-converted files were completed in time for this testing.

Two of the manually built files--the HBP and lab certification files--were set up before the testing, but maintenance was performed on them up until the week before the startup dates. Despite the maintenance, the EDSF representative said the files were able to be tested during the model office testing. In addition, the carrier made sure all functions in the lab certification and HBP files were working properly. The durable medical equipment file, also manually converted, was the only file not ready for model office testing. The system capability was tested, but the data in the file were not set up until the week before startup.

HCFA's review of the carrier during the transition was limited to monitoring not assisting

In December 1978, the month after Buffalo Blue Shield was awarded the Medicare part B contract for upstate New York, HCFA officials identified the major transition activities that required coordination and monitoring by them.

1/Basically a simulation of actual claims processing situations.

2/EDSF is also the data processing subcontractor to Blue Shield of Massachusetts in the Maine experiment.

Staff were assigned not to assist the carrier in completing the tasks, but rather to monitor each activity and to be sure all tasks within each major activity were completed on schedule. HCFA held monthly transition meetings, attended by officials of Buffalo Blue Shield and the outgoing carriers, to keep abreast of the transition activities. HCFA also required the carrier to submit biweekly status reports. These reports contained explanations for delays in completing tasks and a complete list of all tasks indicating their estimated and actual completion dates.

HCFA assigned 13 staff members to the transition effort on a full- or part-time basis. The total time spent by them through October 1, 1979, the end of the transition period, was 439 staff days. Most of this effort was spent on coordination activities, review of procedure code conversion, system testing, and attendance at transition meetings. It included 115 staff days spent onsite at the carrier's Binghamton offices.

As indicated above, HCFA's review of Buffalo Blue Shield's performance primarily involved reviewing and testing file conversions and the claims processing system and approving the procedure coding system to be sure the carrier was ready for "live" operations. In accomplishing this, HCFA officials maintained files and records of their work and prepared detailed reports of their tests and reviews. Their efforts in these areas are described below.

File conversions were tested

HCFA's efforts in Buffalo Blue Shield's file conversion tasks basically involved testing and approving the conversions. This included verifying the accuracy of

--conversion of provider address files and pricing files for each of the three carriers and

--history file conversions.

HCFA did not test all files set up by Buffalo Blue Shield. Some of the files, principally the HBP and durable medical equipment pricing files and the laboratory certification files, were not completed when HCFA conducted its review. HCFA, consequently, did not review these files or reviewed only the completed parts. We are not aware of any problems occurring with these files, however, once the carrier began operations.

The provider files were tested in Binghamton by comparing a sample of files from the previous carriers with data in Buffalo Blue Shield's files. HCFA found no major problems in this area.

To test the beneficiary claim history file, HCFA selected a sample of histories from each of the prior carriers and compared them to the new files. HCFA found some discrepancies, particularly in the conversion of Metropolitan's history records. After HCFA informed Blue Shield of the discrepancies, the carrier contacted Metropolitan and clarified the data. According to HCFA, all discrepancies were ultimately cleared up and approval was given to Buffalo Blue Shield to use the files.

Procedure code matching was approved on time

HCFA's review of Buffalo Blue Shield's procedure code matching was a time-consuming task, requiring 72 staff days. HCFA was required to review all matching performed by Buffalo Blue Shield for each carrier. HCFA and Buffalo Blue Shield had several disagreements in each review; but all were eventually resolved, and HCFA was able to approve the procedure code matching for each carrier before Buffalo Blue Shield started processing claims in its service area.

Various tests performed on the claims processing system

HCFA completed various tests to verify the accuracy of Buffalo Blue Shield's claims processing system. It did not, however, participate with the carrier or EDSF personnel in implementing EDSF's model office test plan for checking the computer system.

HCFA's testing primarily involved conducting a modified carrier system testing project, processing previously processed claims through the new system, and observing the online entry 1/ of other test claims. The testing project conducted by HCFA was not the full test package generally used to test carrier systems; instead, HCFA completed a minipackage of 45 claims. Discrepancies occurred in the test, but they were explained by or resolved with the carrier.

HCFA selected 50 to 100 previously processed claims from each of the prior carriers and processed these claims through the new system. It then compared the old and new results. Differences did occur, but again HCFA personnel said all differences were eventually cleared up.

HCFA also had Buffalo Blue Shield personnel enter test claims directly into the system at the computer terminals. HCFA monitored the input and noted how the system handled various types of errors. The process disclosed no major problems.

1/Involves the direct entry of data into the computer. This approach differs from that followed in the testing project, where carrier personnel do the data entry unobserved by HCFA.

INITIAL IMPLEMENTATION RESULTED IN UNSATISFACTORY PERFORMANCE

The initial months of Buffalo Blue Shield's operations as a fixed-price contractor were characterized by large claims backlogs, poor quality assurance results (high clerical error rates), and many beneficiary and provider complaints. These problems lasted for about 6 months, but since then the carrier's performance has been satisfactory.

Initial claims backlog was high

One of the first problems to arise when the carrier began processing claims under the new contract was a high claims backlog. In June and July 1979, when it was processing only the claims from its previous service area, there was little difficulty. However, the carrier processed fewer claims than it received from August 1979 through October 1979, and a backlog developed. In addition to the increased workload brought on by the added territories, Buffalo Blue Shield received between 81,000 and 117,000 unprocessed claims from Metropolitan and Rochester Blue Shield during the changeover process. 1/ By the end of October 1979, the carrier had a backlog of over 197,000 claims--over three times the backlog experienced by the three previous carriers a year earlier.

The backlog did not last long. By the end of January 1980, the backlog was below the prior year's level.

Quality assurance results were poor

Along with the high claims backlog, Buffalo Blue Shield processed claims poorly in its first several months. The carrier quality assurance program indicated that the carrier had a high error rate in its claims processing. Not until the fourth quarter of its operations did the carrier lower its error rates to about the level in Buffalo and close to Metropolitan's rates.

1/Carrier workload reports from Metropolitan and Rochester showed 69,528 claims and 11,545 claims, respectively. Buffalo's workload reports, and its comments on our report (see p. 100), showed the figures to be 102,471 claims and 14,683 claims. It appears, however, that whichever figures are more accurate, the impact was less than anticipated by Buffalo Blue Shield. In its proposal to HCFA, Buffalo estimated the transferred workload to be about 280,000 claims, and presumably planned accordingly.

Buffalo Blue Shield's error rates since the experimental contract started and the quarterly contract standards 1/ are shown below.

Quarter ended	Occurrence error rate		Payment/deductible error rate		Total estimated payment/deductible error
	Buffalo	Contract standard	Buffalo	Contract standard	Buffalo
					(millions)
Sept. 1979	15.4	(a)	3.9	(a)	$1.4
Dec. 1979	13.4	(a)	4.7	(a)	3.6
Mar. 1980	7.5	8.4	2.0	2.1	1.8
June 1980	4.2	7.4	1.5	1.9	1.2
Sept. 1980	5.7	8.0	1.6	2.0	1.4
Dec. 1980	4.4	7.4	1.2	1.6	1.1
Mar. 1981	4.3	7.3	1.0	1.7	0.9
June 1981	4.0	6.6	1.2	1.6	1.1

a/Contract standards did not apply until the quarter ended March 31, 1980.

Buffalo Blue Shield had a total estimated payment/deductible error of about $12.5 million from July 1979 through June 1981. This amount is about evenly divided between overpayments and underpayments.

The three prior carriers had error rates during 1978 ranging from 3.0 to 7.7 for occurrence errors and 1.2 to 4.4 for payment/deductible errors. Their combined payment/deductible error rate was 1.9 percent.

1/The standards for error rates are the same as in the Maine contract. Buffalo Blue Shield's error rates must be less than those of 60 percent of all other carriers each quarter.

Correspondence backlog developed

During the quarter ended December 31, 1979, its first quarter processing claims for the entire upstate area, Buffalo Blue Shield received about 30,000 requests for review and 22,400 other pieces of correspondence. Comparable figures for the prior carriers, a year earlier, were 7,500 requests for review and 13,600 pieces of other correspondence. Although Buffalo Blue Shield processed more reviews and correspondence than the prior carriers had the previous year, large backlogs developed. The carrier's pending review backlog at December 31, 1979, was 21,394--more than 10 times the prior carriers' level at December 31, 1978. Pending correspondence levels were similarly high--7,878 for Buffalo Blue Shield at December 31, 1979, compared to 1,433 for the prior carriers a year earlier. Buffalo Blue Shield's review and correspondence workloads remained at high levels until the quarter ended June 1980.

REASONS FOR THE INITIAL POOR PERFORMANCE

Several factors contributed to Buffalo Blue Shield's initial poor performance. These included the inexperience of the carrier's staff, the medical policy differences among the carriers, the difficulty in obtaining accurate files from the prior carriers, and a "specialty-merge problem." 1/ Three of these factors--the inexperienced staff, medical policy differences, and difficulty obtaining accurate files--could be expected to occur in implementations of fixed-price contracts and were addressed in our June 1979 report. The specialty-merge problem, possibly unique to the New York experiment, points out the problem of changing reimbursement policies during the implementation of an experiment when the effects of such policy changes is not one of the experiment's objectives.

Carrier staff was inexperienced

Both Buffalo Blue Shield and HCFA officials stated that the inexperience of the carrier's staff in processing Medicare claims was a major reason for the initially large claims backlog, high error rates, and high correspondence and review levels. In evaluating Buffalo Blue Shield's technical proposal for the contract, HCFA considered the experience of management staff, but did not consider the experience of supervisory or lower level staff.

1/As discussed on page 43, this problem resulted from a change in reimbursement policy where some providers would receive less Medicare reimbursements than they or their patients were previously receiving.

In establishing a new operation in Binghamton, the carrier had to hire all new staff except for some top management personnel. 1/ The director and five of his managers were transferred from Buffalo. Five other managers and assistant managers and all supervisory and clerical staff were hired in Binghamton. According to Buffalo Blue Shield officials, they chose to locate in Binghamton to keep labor costs down. The wage rates were lower in Binghamton than in Buffalo, and the work force was not unionized.

Although the carrier undertook extensive training programs, it expected initial results to be poor because of the new staff. Analysis of the quality assurance results during the period October to December 1979 demonstrated the staff's inexperience and unfamiliarity with Medicare regulations. Over 87 percent of the payment/deductible errors and 80 percent of the occurrence errors were coding errors and incorrect applications of Medicare coverage guidelines. 2/ By the next quarter, however, the staff's performance improved as they gained more experience. As discussed later, the carrier met the quality assurance performance standards beginning with the January to March 1980 quarter.

Medical policy differences existed between Buffalo Blue Shield and the prior carriers

Carrier officials told us that their conservative medical policy was responsible for some of the increased levels of correspondence and requests for review during the initial implementation. HCFA generally agreed with them, stating that in most areas Buffalo Blue Shield's policies were more conservative, but added that Metropolitan's and Rochester Blue Shield's policies in certain

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1/In commenting on our report (see p. 102), Buffalo Blue Shield pointed out that the need for cost-effective operations and a centralized location virtually assured that any successful bidder would have needed to establish a new location and to employ inexperienced staff. Blue Shield further stated that any contractor would have had a staff with about the same level of inexperience.

Whether other bidders would have decided not to locate near previous carriers' operations and possibly hire more experienced personnel, or even whether these other bidders would have been successful had Buffalo not based its proposal on a move to Binghamton, is not evident to us. Thus, we cannot comment on the validity of Blue Shield's comment about any successful bidder having to move its operations and hire new and inexperienced staff.

2/HCFA's instructions to all part B carriers contain guidelines as to what medical services are not covered.

areas were more restrictive. The differences covered various carrier operations, including coverage guidelines, prepayment screens, and reasonable charge calculations.

There were a number of differences in coverage guidelines among the three previous carriers. Buffalo Blue Shield did not significantly change its guidelines when it started operations in Binghamton; thus, the differences remained. HCFA staff provided us with the following examples of these differences.

--Buffalo Blue Shield is very restrictive in payment for concurrent in-hospital care. It normally pays for only one doctor, and any others must be justified in writing. Conversely, Metropolitan normally paid for concurrent care.

--For in-office surgical procedures, Metropolitan paid for both the office visit and the surgical procedure. Buffalo Blue Shield denied the visit charge and paid for only the surgical procedure.

--Medicare regulations regarding the payment of consultation fees and followup daily visits were interpreted differently by Buffalo Blue Shield and Metropolitan. Metropolitan changed the consultation to a first visit and paid the additional daily visits. Buffalo Blue Shield pays the consultation fee and denies the daily visits.

--Buffalo Blue Shield considers the drawing of blood for laboratory services as routine and denies payment if charged separately. Rochester Blue Shield paid for this.

Medical policy differences also were evident in the prepayment screens 1/ used by Buffalo Blue Shield and the prior carriers. In a comparison of 30 screens prepared by Buffalo Blue Shield, we concluded that the carrier generally had tighter screens than Rochester Blue Shield and Metropolitan. In several cases, however, Buffalo Blue Shield loosened its previous screens when it assumed control of the entire upstate area.

Another area where differences were noted was in reasonable charge calculations. HCFA gave us the following examples.

1/The computerized or manual application of various medical policy criteria to claims before payment. Such screens are to identify questionable services and to suspend the claims for further review. For example, a screen may be established that would allow claims containing up to eight office visits in a month for a beneficiary to be processed normally. Claims for more frequent office visits would be suspended for review.

- --For physician charges for inhospital visits, Rochester Blue Shield's procedure coding system established reasonable charge data according to days of service. A charge was calculated for service on the first day, a second charge for services performed on the second through seventh days, and a third charge for the eighth day on. Buffalo Blue Shield's and Metropolitan's calculations differed from this. They developed a reasonable charge for the first day's visit, but charges thereafter are based on the level of service provided, such as brief visit or comprehensive lengthy visit.

- --Rochester Blue Shield did not develop customary charges for its providers, but relied on established fee schedules used in its private lines of business. Buffalo Blue Shield and Metropolitan developed customary charge profiles for individual providers.

The carrier claimed Metropolitan provided inaccurate provider profiles

Carrier officials claimed that Metropolitan provided them with inaccurate, insufficient, and illegible provider profiles. They contended the profiles caused many incorrect reimbursements resulting in additional telephone inquiries, correspondence, and requests for review. The officials stated they ultimately had to adjust over 500 profiles.

HCFA, which had approved the profiles transferred to Buffalo Blue Shield, disputed the carrier's contention and said the problems were caused mainly by Buffalo Blue Shield's inexperienced staff. A Metropolitan official told us that Blue Shield's staff read the profile data inaccurately and did not ask Metropolitan for clarification until after the complaints began coming in.

The "specialty-merge problem" caused some of the provider and beneficiary dissatisfaction

Metropolitan, the largest of the prior upstate carriers, was required by HCFA, beginning in July 1979, to develop new prevailing charge schedules without regard to medical specialty. 1/ Buffalo Blue Shield and Rochester Blue Shield were already preparing prevailing charges in this manner. The change meant that all physicians would have the same prevailing charge for a particular service regardless of whether they were a general practitioner or a specialist. In some cases, this would result in a rollback situation where providers, usually specialists, would receive less than they or their patients were previously receiving.

1/In May 1981 a U.S. district court in Michigan ruled that the carrier in that State could not differentiate for specialists in determining prevailing charges.

Buffalo Blue Shield officials realized that the change would raise many complaints and requests for review from specialists who received less. Since the carrier was taking over Metropolitan's service area in August 1979, officials believed providers and beneficiaries would blame them for the reduced payment. To prevent this Buffalo Blue Shield requested that HCFA include a no rollback provision in its requirements, but HCFA refused. Data developed for HCFA by Metropolitan showed that only 6 of the 50 most common procedure codes would result in a lower reimbursement rate. HCFA concluded from this that combining specialties would have only a minimal impact.

Buffalo Blue Shield disagreed with HCFA's conclusion and began taking steps in July 1979 to counter any potential adverse situation. These steps included

--identifying physicians and procedure codes most affected by the rollback,

--notifying the affected physicians and informing beneficiaries,

--personally contacting high-volume billers to discuss effects of rollbacks on cash flow, and

--providing rollback information to Social Security district offices in urban areas most affected to alert them to possible beneficiary complaints.

Carrier officials believe that these actions helped reduce the provider and beneficiary unrest caused by the specialty merge, but pointed out that it was still a major cause of the high review and correspondence levels and poor provider relations. HCFA recognized it as a problem, but stated that other problems, such as the carrier's inexperienced staff, were the major cause of the initial problems. In any event, HCFA officials maintained that the requirement for the specialty merge was stated in the RFP for the fixed-price contract and should have been considered by Buffalo Blue Shield in preparing its bid.

OVERALL PERFORMANCE HAS BEEN SATISFACTORY

After its initial unsatisfactory performance from June to December 1979, Buffalo Blue Shield's overall performance has shown much improvement. Contract standards with associated penalties did not apply until the January to March 1980 quarter. Since January 1980, the carrier has passed 69 of the 72 standards evaluated.

Monitoring system same as Maine

Under terms of the fixed-price contract entered into by HHS and Buffalo Blue Shield, HCFA is required to continually assess the carrier's performance. The contract includes basically the same two-faceted system of workload-related standards and functional standards as used in the Maine contract (see p. 21). Financial penalties are different, however. Beginning with the January to March 1980 quarter, Buffalo Blue Shield is to be assessed $37,000 for each standard failed.

Most contract standards have been met

For the six evaluation periods (quarters) ending June 30, 1981, Buffalo Blue Shield has passed 69 of the 72 standards evaluated. Two of the failed standards were in System One and involved the average processing time for handling informal reviews. The other was a System Two standard--beneficiary services and professional relations.

The carrier initially failed three other System Two standards. However, the problems were corrected during a grace period allowed under the contract and, thus, the standards were considered met.

The HCFA regional office in New York has recommended that Buffalo Blue Shield be assessed liquidated damages for failing to process reviews in 25 days or less during the quarters ended March and June 1980 and for providing poor telephone service during the January to March 1980 quarter. Carrier officials have contested the liquidated damages primarily because they believe the deficiencies were caused by problems beyond their control--specifically, the specialty merge and the alleged poor files provided by Metropolitan. Their objections were sent in writing to the HCFA central office on May 29, 1980. As of October 21, 1981, a decision on the assessment of liquidated damages had not been made.

In commenting on our report (see pp. 99 to 103), Buffalo Blue Shield referred to its May 29, 1980, letter and objected to our report's description of its performance during the initial months of claim processing as unsatisfactory. It said the report did not reflect the gravity or the impact of the specialty-merge problem, the problems created by the differences in medical policy, and the inadequacy of the provider information Buffalo received from Metropolitan.

We did not evaluate the relative impact of these factors on Buffalo's performance; thus, we cannot comment on the objections raised to HCFA. However, such an evaluation appears to be included in the study HCFA has planned for the experiments (see p. 15).

FINANCIAL STATUS NOT EVALUATED

Buffalo Blue Shield did not submit a final administrative cost report for fiscal year 1980 until September 17, 1981, although the contract required it to do so by the end of December 1980. In its September 17, 1981, letter to HCFA, Buffalo Blue Shield stated that the report submitted includes trade secrets and privileged, proprietary, and confidential information which in its view is not subject to disclosure. We have not included the data in this report because of Blue Shield's concerns, and we did not have sufficient time to pursue this confidentiality issue with HCFA.

Such reports should be helpful in evaluating whether the contract price paid to Buffalo Blue Shield is sufficient to cover its operational costs. This information is useful in judging the future benefits from this form of contracting because it would be unreasonable to expect contractors to continue losing money. The other fixed-price contractors appear to be losing money (see pp. 25 and 65); thus, future competitively awarded fixed-price contracts should not be expected to result in as much administrative cost savings as the first three experiments.

CONCLUSIONS

Medicare's fixed-price contract experiment in upstate New York is progressing smoothly after some initial performance problems by Buffalo Blue Shield. The transition phase of the experiment was completed successfully by the carrier and HCFA. The carrier was able to meet its scheduled startup dates to process claims from the prior carriers despite delays in some transitional tasks. HCFA's efforts to oversee the transition appeared to be thorough.

Buffalo Blue Shield's initial unsatisfactory performance was reflected in its high claims backlog, poor quality assurance results, and high correspondence and review levels. Much of this was caused by problems which could be experienced by any Medicare carrier in taking over a new service area. They included a new and inexperienced carrier staff, medical policy differences between Buffalo Blue Shield and the prior carriers, and the difficulty of converting files from the prior carriers.

Another reason for the carrier's initial unsatisfactory performance was the specialty-merge problem. Changes in Medicare reimbursement policies like the specialty merge occasionally occur, but implementing such a change during the initial stages of a fixed-price experimental contract caused difficulty for the new carrier and created additional confusion among providers and beneficiaries. In addition, it makes evaluating the experiment more difficult.

Buffalo Blue Shield's performance after its poor start has improved considerably. The carrier is more accurately and quickly processing Medicare claims then it did in the first 6 months, and its processing time for reviews is much better than the contract standard.

BUFFALO BLUE SHIELD COMMENTS AND OUR EVALUATION

In commenting on a draft of this report (see pp. 99 to 103), Buffalo Blue Shield objected to being presented as in the middle between the results of the satisfactory Maine experiment and the unsatisfactory results of the Illinois experiment--thus implying that its performance was "less than satisfactory." The carrier pointed out that, in comparison with the Maine experiment, (1) it had saved the Government more money in terms of administrative and benefit costs, (2) it had overcome more serious difficulties beyond its control than were experienced in Maine, and (3) overall it had passed 57 of 60 standards (95 percent) through the quarter ended March 31, 1981, while the carrier in Maine had passed 136 of 144 (94.4 percent).

In our opinion, our report has not denigrated Buffalo Blue Shield's overall accomplishments or the problems it overcame. However, the higher administrative cost savings attributed to the New York experiment are more a result of the initial competitive procurement process than of a contractor's performance during implementation. In documents supporting Buffalo's response, the benefit cost savings were principally attributed to the carrier's significantly higher claims denial rate than one of the previous carriers (Metropolitan). Although this is true, without applying a rigorous and costly evaluation methodology, we have no way of judging what Massachusetts Blue Shield would have done in upstate New York, or for that matter, what Buffalo Blue Shield would have done in Maine.

Also, we have not attempted to fix responsibility for the problems experienced during the first 6 months of the New York experiment, but attempted to report as objectively as possible what happened and the contributing causes. Finally, we believe it is difficult to make any value judgment as to the meaning of the difference between 94.4-percent and 95-percent compliance with the contract standards in two different environments.

Our conclusion regarding the relative success of the New York experiment as compared with the Maine experiment was based solely on a comparison of the performance results during the first 6 months of implementation. These results, which are summarized in the following table, show that the initial implementation in Maine went far more smoothly than it did in New York. For comparison purposes we used the first two full quarters of the Maine experiment (January to March and April to June 1978) and the first two quarters of the New York experiment (July to September and October to December 1979).

Performance criteria	1st quarter Maine	1st quarter New York	2nd quarter Maine	2nd quarter New York
Percent of claims processed in 15 days or less	82.5	66.0	91.3	55.5
Percent of claims pending over 30 days at end of month	19.0	22.7	(a)	23.2
Occurrence error rate	9.6	15.4	7.1	13.4
Payment/deductible error rate	2.3	3.9	1.6	4.7
Average processing time for informal reviews (days)	(b)	45	16.6	61

a/Number of pending claims over 30 days was under 1,000, so HCFA did not calculate a percentage.

b/Not available.

In our opinion, one of the factors that must be considered in evaluating the competitive fixed-price contract experiments is the tradeoff between the lower administrative costs associated with the competitive procurement process and the deterioration in beneficiary services, and in timeliness and quality of claims processing during and after contractor changeover. In this regard, the period of deteriorated performance becomes a factor in the tradeoff equation. However, the weight to be given this factor is subjective; is 1 month acceptable, or 3 months, or 6 months, or 2 years?

Other major concerns raised by Buffalo Blue Shield have been incorporated in the text of this chapter (see pp. 32, 41, and 45).

CHAPTER 5

THE ILLINOIS EXPERIMENT--A COSTLY AND UNSATISFACTORY EXPERIENCE

The Medicare part B fixed-price contracting experiment in Illinois has been a difficult experience for the program, the Government, the beneficiaries and providers, and perhaps the contractor itself. The contractor--Electronic Data Systems Federal Corporation--began claims processing in Illinois in April 1979 after a 9-month transition period. This was the first contract for EDSF as a carrier in Medicare, although it had been involved previously in Medicare as a data processing subcontractor. Since 1966 EDSF has provided computer facilities management services for Medicare programs in 15 States, and it has developed a reputation for helping several Medicare carriers improve their operations and lower their administrative costs.

EDSF's performance has remained substandard under the terms of the contract during the more than 2 years it has processed claims in Illinois. We previously reported 1/ on the severe problems that occurred during EDSF's first year of operations, particularly in entering data from the claims into the computer. While EDSF has improved in this activity, serious deficiencies continue to exist, particularly in beneficiary services and the administration of program payments. Many of these problems date back to the contract's inception.

EDSF may incur a loss on this contract. According to its unaudited financial reports, EDSF's costs from contract inception to September 30, 1980, exceeded contract payments by $8.5 million. Despite these apparent losses, EDSF has demonstrated the financial commitment to resolving its performance problems.

The contract has been costly to the Government as well. EDSF's payment errors from contract inception to June 30, 1981, have exceeded $67.6 million. While overpayments and underpayments have been almost equal, adjustments favorable to claimants have far exceeded overpayment adjustments; and based on HCFA's quality assurance program and related reports, an estimated $27.7 million in overpayments remain unrecovered. The problematic nature of the contract has necessitated far more HCFA monitoring resources than originally

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1/We testified on April 28, 1980, in Chicago, before the Subcommittee on Health of the House Committee on Ways and Means. We also issued reports on December 16, 1980, to the Subcommittee and to Congressman Paul Simon concerning the results of our investigation of several allegations of questionable actions by EDSF to reduce claims and correspondence backlogs.

planned and has necessitated that HCFA establish a special unit to monitor EDSF exclusively. The estimated savings in administrative costs from the award process and the contract penalties HCFA has collected have been significantly eroded by the Government's additional monitoring costs and the excessive overpayment errors.

HCFA's monitoring of EDSF's activities during the transition of carrier responsibilities was limited. When problems surfaced after EDSF began processing claims, neither EDSF nor HCFA devoted sufficient attention to pinpointing the causes. Thus, inherent problems went undiscovered and continued to surface during the balance of the contract.

CONTRACTOR SELECTION

The Illinois contract, the second experiment with competitive fixed-price procurement, was initiated in early 1978. Medicare part B beneficiaries in Illinois had been serviced by the Health Care Service Corporation (Chicago Blue Shield) in Cook County and the Continental Casualty Insurance Company (Continental) in the other counties. In this experiment HCFA solicited a fixed-price proposal to serve the entire State. Total fiscal year 1978 part B claims volume for Illinois was 3,591,672--1,890,828 claims were processed by Chicago Blue Shield and the other 1,700,844 by Continental.

Among the primary reasons cited by HCFA for selecting Illinois for an experiment were (1) the competitive process should produce a contractor that can operate at substantially lower administrative costs than either Continental or Chicago Blue Shield and contribute to the fiscal year 1979 budget objective of reducing operating costs through the use of fixed-price contracting, (2) concern over having two carriers operating out of Chicago, and (3) by combining the workload of two carriers, the effects of increased workload could be tested. Another factor in the decision was that HCFA considered Continental to be marginal in performance and Chicago Blue Shield close to average.

The RFP called for a total firm fixed price to include all carrier services to be performed in Illinois over the contract's term--July 1, 1978, through September 30, 1983. Actual claims processing began on April 1, 1979, in Cook County, and on July 1, 1979, for the remainder of the State. The 9-month period between July 1, 1978, and the start of claims processing was allowed as a transition period in which the successful bidder would work with HCFA and the incumbent carriers to assure a smooth change.

The RFP called for a total fixed price independent of claims volume. The only adjustments to be considered were increases or decreases in postage or Social Security taxes announced after the bids were received, and major legislative changes that affect the carrier's workload.

HCFA received proposals from five organizations--Chicago Blue Shield, the General American Life Insurance Company, EDSF, Continental, and the Prudential Insurance Company. The other four offerors were existing Medicare carriers.

The award factors used in the evaluation were the same as in the Maine and New York experiments, with a variation in weights: technical (20 percent), experience (35 percent), and price (45 percent). Point awards were made in the same way as the other experiments, with the following results:

Bidder	Total (note a)	Point difference from winning bidder
EDSF	905.27	-
Chicago Blue Shield	887.28	17.99
Continental	846.50	68.77
Prudential	728.54	176.73
General American	684.87	220.40

a/Total points possible--1,000.

EDSF, which finished fourth in the technical category and third in experience, won because of a 45-point advantage in the price category. Prudential, the high scorer in both technical and experience categories, finished low in the overall scoring as a result of receiving the lowest point award for price.

The price proposals were evaluated by HCFA, based on current national average cost experience and the inclusion of implementation and conversion costs. The following table shows the total bid price and the estimated unit cost per bid based on HCFA's projected claims volume.

Bidder	Total price	Estimated unit cost
EDSF	$41,800,000	$2.03
Chicago Blue Shield	46,505,000	2.25
Continental	49,006,000	2.38
General American	79,981,400	3.87
Prudential	81,490,600	3.94

Chicago Blue Shield and Continental had incurred costs of $3.48 and $3.02 a claim, respectively, in fiscal year 1978.

As we pointed out in our June 1979 report, making any specific conclusions about the price proposals is difficult because we do not know what volume levels the companies used in their estimates. More importantly, we do not know what level of services each company planned to provide in such areas as beneficiary and provider services, pre- and post-payment utilization review, and fraud and abuse detection. However, in terms of total fixed price, it appeared that substantial savings in administrative costs would occur. We estimated that the previous carriers in Illinois would have incurred about $62.4 million in costs over the contract's operational period. Thus, the successful bid saved an estimated $20.6 million 1/ in administrative costs.

EDSF CONTINUES TO FAIL CONTRACT STANDARDS

EDSF's performance has remained substandard under the terms of the contract during the more than 2 years it has processed claims in Illinois. Since the contract standards went into effect with the quarter ended December 31, 1979, EDSF has failed 55 of the 84 standards. 2/ Most of these failures are in the workload-related standards which EDSF has met only 5 times out of 45, including the first 6 months of the contract when financial penalties (liquidated damages) were not applicable.

Of the 12 contract standards, EDSF has consistently failed 6 to 9 of them each quarter. Six of the standards have never been passed. As shown by the table in appendix II, however, there has been a gradual improvement in its performance against some of the standards, and during the second year, its performance began to compare favorably with that of the previous contractors.

HCFA monitors EDSF's performance through workload reports prepared by EDSF, a quarterly claims quality assurance analysis performed jointly by EDSF and HCFA, and a series of quarterly inspections and tests designed to evaluate specific aspects of EDSF's operations. Quality assurance analysis of claims and the reporting of workload data began with EDSF's first quarter of operation. Formal monitoring of EDSF's performance and assessment of penalties against the contract standards began with the quarter ended December 31, 1979.

As in the other two experiments, HCFA's monitoring is divided into two parts. System One measures the timeliness and quality of EDSF's claims processing and the timeliness of its formal reviews.

1/As discussed on page 58, HCFA has paid EDSF about $3 million for its reported costs to correct an underpayment situation involving about 1.5 million claims. Thus, the estimated savings over the entire contract period would be reduced by this $3 million.

2/Five of the failures are considered tentative as EDSF has an opportunity to correct the deficiencies found and reverse HCFA's decision.

System Two deals with EDSF's performance in seven functional areas. The contract provides a minimum 15-day grace period in which EDSF can correct a System Two deficiency.

The System One and Two standards are HCFA's basis for applying liquidated damages on the contract. If EDSF fails the established performance standards in any quarter, its remuneration is reduced by $52,250 for each standard it fails, starting with the quarter ended December 31, 1979. EDSF is subject to $2.9 million in liquidated damages for failing to meet the contract standards through the quarter ended June 30, 1981--$1.6 million for failing System One standards and $1.3 million for failing System Two standards. 1/

HCFA SHOULD SHARE SOME OF THE RESPONSIBILITY FOR UNSATISFACTORY PERFORMANCE

Some of the difficulties EDSF has experienced during its operations in Illinois can be traced to difficulties in the early stages of the contract. 2/ Some of these difficulties may not have been apparent to EDSF because of its inexperience as a Medicare carrier. HCFA's regional staff was not prepared to deal with an inexperienced carrier and, thus, missed opportunities for earlier identification of problems.

Neither EDSF nor HCFA devoted sufficient attention to pinpointing the problems' causes. Instead, the primary focus of both EDSF's and HCFA's attention was on paying claims.

HCFA and EDSF are now working on problems that should have been identified and corrected during the contract's transition phase or early in the implementation phase. The delay in these corrective actions slowed EDSF's progress in improving its performance.

1/As of October 21, 1981, HCFA has officially assessed EDSF a total of $1.8 million. Also, EDSF may be subject to another $1.1 million in penalties based on the standards failed through the quarter ended June 30, 1981, although it has an opportunity to correct some of the deficiencies during a grace period. (See app. II.)

2/Some of the difficulties are not discussed in this report because they were discussed in our April 1980 testimony (see p. 49). In that testimony we discussed some of the causes of EDSF's workload problems, particularly its problems with maintaining a stable workforce. We also discussed the steps being taken to deal with the problems, including its decision to open two additional claims processing offices.

Insufficient scrutiny of EDSF's transitional tasks

Although HCFA's scrutiny of the contractor's activities during the transition is largely undocumented, it was apparently insufficient. EDSF's inexperience as a carrier, plus the scope of work involved in the changeover, necessitated a more thorough scrutiny by HCFA in the carrier transition. Only a few of the staff brought in by EDSF to manage the operations in Illinois had experience in Medicare. EDSF's proposal cited an impressive list of people who would manage the Illinois contract. According to HCFA, however, few of these people actually worked on the Illinois contract.

Procedure code problems

The changeover in Illinois, as in New York, was complicated because it involved merging the operations of two carriers into a single operation. To do this, EDSF was required to implement a single procedure coding system instead of two different systems used by the previous contractors. Payments made by the prior carriers had to be translated into this new coding system.

The procedure coding system proposed by EDSF in its technical proposal was the one used by Blue Shield. It was EDSF's intention, as one of its major transitional tasks, to convert the coding system used by Continental to that used by Blue Shield. However, according to EDSF and HCFA regional officials, it was decided during the transitional period that neither incumbent's system was compatible to EDSF's computer system. EDSF began work instead on a coding system different from both prior contractors' systems.

A former director of EDSF's Illinois operations told us that, before EDSF prepared its proposal to HCFA, problems with Blue Shield's coding system, including its incompatability with EDSF's data processing system, were known. EDSF officials also told us they expected HCFA to approve the use of CPT-4 1/ as an alternative coding system. CPT-4 is used by Illinois' Medicaid program and, thus, is familiar to many providers.

On November 29, 1978, EDSF requested HCFA to approve the use of CPT-4. The RFP, however, specifically stated that the coding system to be used could be either of the existing Illinois Medicare systems or another system then approved for use by HCFA at other Medicare carriers. CPT-4 was not approved for use at any Medicare carrier, and EDSF's request to use it was denied.

1/CPT-4--the Current Procedural Terminology, 4th Edition, which is published by the American Medical Association.

There is little documentation available at either EDSF or HCFA to trace the step-by-step efforts to develop the coding system. There is evidence, however, that EDSF did begin work on another coding system before the use of CPT-4 was denied. In December 1978, EDSF began giving segments of its coding system to HCFA for approval. Final approval was not given until April 24, 1979, although preliminary approval was given on February 5.

Although EDSF's procedure code conversions were essentially approved by HCFA before April 1, both EDSF and HCFA made a significant "hurry-up" effort to get the system approved.

EDSF's former medical advisor, who was hired in July 1979, told us in April 1980 that the coding system needed improvement. She said the coding system was poorly organized and contributed to the poor data entry results that had been identified. She specifically cited three groups of medical procedures that were left out of the cardiovascular [1] section of EDSF's coding system, one that was out of date, and others that were impractical.

Impact of system differences apparently not evaluated

As discussed in chapter 3, any new contractor taking over from a previous carrier is likely to change certain operational features or procedures from those adopted by the previous carrier. These differences, particularly if resulting in lower reimbursement amounts, can have a negative impact on providers and beneficiaries. To evaluate this impact, and perhaps attempt to minimize it, requires a concerted effort by both HCFA and the new contractor.

In Maine, as we reported on page 26, such a concerted effort was made to minimize the impact of system differences, and it was successful. The tasks, however, were easier than the New York and Illinois experiments because of several factors--chiefly, the smaller workload and the fact that only one carrier was being replaced. Illinois was a more complicated situation. Not only were two carriers' operations to be replaced by one, but the existing carriers had many operational differences. Replacing them with a contractor with other operational differences further compounded the difficulties, in our opinion. HCFA recognized these differences in a March 19, 1980, report on the experiment:

> "A related cause of all the attention the experiment is receiving is the fact that neither HCSC [Blue Shield] or CNA [Continental] was nearly as devoted to automated processing as is EDSF. While both HCSC and CNA used automated systems, they also relied

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[1] Pertaining to the heart and blood vessels.

> heavily on clerical intervention, especially in determining reasonable charge. Also, in handling correspondence, they attempted to tailor their responses to the situation. HCSC, in particular, had high administration costs reflecting some of these operational characteristics. EDSF, on the other hand, has the opposite philosophy in that they rely on a highly mechanized process, e.g., minimum intervention, minimum independent judgement, an automated correspondence system whereby letters are mass-produced by merely entering codes, etc. Perhaps we should have anticipated the ensuing culture shock and minimized it by requiring certain methods to continue for awhile. We realize such an effort would make the contracting process more difficult (i.e., much more information about the incumbent contractors' and offerors' methods would be necessary) and that some of the financial savings the fixed price is designed to generate would likely be offset. However, we believe beneficiaries, providers, and taxpayers would be better served by such experiments if more consideration is given to retaining some familiar methods and the overall effect of the change in contractors in terms of the real money issue which is the amount of benefit dollars paid. So far, our RFPs have not addressed this area to any extent."

The situation should have necessitated a thorough HCFA review of EDSF's transitional tasks, particularly the operational readiness and accuracy of its data processing system and the conversion and development of the many data files used to process claims. It should also have required HCFA to measure the possible impact of EDSF's processing differences, and possibly to minimize this impact.

We found little evidence that either HCFA or EDSF attempted to measure this impact. Most of HCFA's time appears to have been taken up by the procedure coding conversion. Since this work on the procedure coding took so long and continued even after EDSF began operations, we believe this severely limited HCFA's and EDSF's ability to complete a careful review of the many transitional tasks. A systematic review and correction of files, such as that completed by HCFA's New York Regional Office staff (see pp. 36 and 37), was apparently not done in Illinois.

System testing

EDSF did test its data processing system using the model office approach followed in other Medicare system implementations. [1] It told us that the model office testing was highly successful and that the problems encountered during the first several months of operations were not related to computer system problems.

Because of the many complaints and problems which surfaced, we attempted to review the adequacy of EDSF's testing. We were unable to review the completeness of its tests, however, since a complete description of the tests made, the results obtained, and EDSF's subsequent corrective actions was not available. HCFA's regional staff told us they did not observe EDSF's model office testing, although they did review and approve the plan submitted by EDSF.

EDSF told us that the procedure coding difficulties did not affect system testing. It stated that testing of all phases--including edits, audits, development, pricing, explanations of Medicare benefits, and reporting--did not depend on having a procedure code file which was 100-percent finalized.

We do not agree, however, unless EDSF is referring strictly to testing of its software logic. We believe a thorough review of all files converted from the previous carriers, followed by comparative analyses of claim processing results of EDSF's system with those of the previous carriers, requires an accurate and complete procedure code system. We also believe such a review is an essential part of testing a claims processing system. Also, the HCFA staff responsible for overseeing the transition told us that their subsequent experience with EDSF's processing problems led them to conclude that EDSF's model office tests were not representative of actual claims EDSF would receive.

HCFA made its own test of the EDSF system before it became operational using a modified version of its Carrier Systems Testing Project--a standard package developed by HCFA for such tests. The full test, however, was not run; only a mini-package of 41 claims (less than a third of the test claims in the standard package) were used. We have reservations about this testing package's ability to adequately test the readiness and accuracy of a carrier's processing system, even if the full test is run. We are currently reviewing this project and have discussed our concerns with the HCFA central office staff responsible for the testing project (see page 134). The HCFA staff responsible for this project told us the mini-package was used because not enough time was available to run the full test. They pointed out that, if the full test had been run, some of EDSF's processing problems might have been detected earlier.

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[1] See p. 35. As previously pointed out, EDSF is the data processing subcontractor to the carriers in the other two experiments.

We also believe that some of the problems later encountered by EDSF could have been detected and avoided with more testing or quality review during the transitional period. The problems we are referring to are principally those relating to the files converted or developed for use in Illinois--such as the provider file, which contains the names and addresses of physicians and suppliers authorized to furnish and bill for Medicare services; the reasonable charge pricing files; the hospital-based physician file, which contains the amounts used to pay hospital-based physicians; and the procedure code file. Problems with these files caused inaccurate and different reimbursements to providers and beneficiaries from those previously experienced by them.

Whether other problems, such as the mailing of unnecessary and confusing letters to claimants, were preventable by additional testing is not clear to us. In commenting on our report, EDSF stated that they were the result of clerical errors, not system problems.

We were unable to trace the underlying causes of all of EDSF's problems. However, during the first 15 months of operations, EDSF's records indicate a total of 182 system changes. Although most of these were considered to be system enhancements, at least 60 were to correct identified system problems, including some which appeared to us to relate to reimbursement problems, as well as letters to beneficiaries and providers. Whether this number of changes is unusual for Medicare system implementations we do not know.

In commenting on our report (see p. 133), EDSF stated that the volume of system changes was low when compared to previous system implementations. Further, EDSF stated that 62 of the changes were documented as system problems. Of these EDSF said only 16 were identified as situations which could have adversely affected (1) payment or disposition, (2) claimant interpretation, or (3) incorrect notification or development.

Problems with files

A problem with the pricing files transferred from Continental to EDSF was not discovered by HCFA until the end of November 1980--about 2 years after the transfer of the data. In reviewing revisions made to several procedure codes, HCFA found errors in the reasonable charge pricing files used to pay certain medical services rendered in the area previously serviced by Continental. The result of these errors, according to HCFA, was a reduction of some Medicare payments since July 5, 1979, by about 5 percent.

EDSF has been required to correct all payments made incorrectly as a result of these errors. The corrections, as of September 18, 1981, total about $3.6 million in retroactive payments to beneficiaries and physicians on about 1.5 million claims. HCFA has reimbursed EDSF about $3.0 million for its reported costs to make the corrections.

Problems were also found with the provider file, which contains the names and addresses of physicians and suppliers authorized to furnish Medicare services. The principal problem was the multiple listings for many physicians who, according to HCFA regional staff, should not have had more than one number. HCFA officials acknowledged that they did not review this file when it was developed by EDSF during the transition, nor is it reviewed during HCFA's regular quarterly monitoring.

Although we do not know the exact number of incorrect provider listings or multiple entries, we did identify many cases of duplicate payments being made as a result of multiple account numbers. We are continuing our analysis of these duplicate payment situations and will report on them later.

Commenting on our report, HHS said we were construing the lack of total documentation and the failure of the HCFA regional office to write a report on the transition and implementation to mean that the regional office's monitoring of the transition was limited. It pointed out that the regional office devoted about 4.5 staff years to the transition and participated in the transition activities/tasks outlined in EDSF's proposal.

Our conclusions regarding the regional office's limited monitoring were based principally on discussions with regional staff concerning their activities and on comparisons between the tasks performed by the three regional offices involved in the experiments. The most noticeable difference was in the review of critical files set up by the new carriers and in the review of claim output differences between the previous carriers and the new carriers. With the exception of a limited review of 48 claims, we found no evidence that HCFA's Chicago Regional Office reviewed EDSF's claim processing results and compared them with those of the prior carriers. In fact, had such a review been done, we believe HCFA may have discovered the problems with the pricing files used to pay claims from the area previously serviced by Continental.

Monitoring plan does not hold EDSF accountable for its technical proposal

The monitoring plan HCFA developed attempts to measure EDSF's performance on the functional standards outlined in the RFP. It does not, however, hold EDSF accountable for complying with many of the provisions stated by EDSF in its technical proposal. It also was not used by HCFA during EDSF's first 6 months of operations. As a result, EDSF was able to defer some of the actions for which it was responsible without being subject to HCFA review and reporting. It also was able to avoid some of the things that the technical proposal stated it would do.

During the first 6 months of EDSF's claims processing, HCFA accumulated the data reported under System One, although penalties were not assessed. This allowed it to pinpoint problems and seek EDSF's corrective actions. The absence of System Two monitoring allowed some of these functions to go unaddressed for the first 6 months of operations. For example, although EDSF had a program integrity unit on paper as of May 1979, it did not hire people to staff the unit until August and the unit did not become operational until November. As a result, important program integrity functions, such as postpayment utilization surveys and audits of teaching physicians, [1] were not performed.

Price was HCFA's primary reason for awarding EDSF the Illinois contract. EDSF's technical proposal, however, outlined many mechanisms that were to assure its success in Illinois, despite its lack of an existing base of operations in the State or experience as a Medicare carrier.

HCFA's monitoring does not address the extent to which EDSF is fulfilling many of the items stated in its proposal. For example, although EDSF's system has the capability to use force or override codes to bypass certain consistency checks, [2] the computer was to produce a report that identifies the force codes used, the frequency of use, and the individuals using them. Documentation is required by HCFA on all computer systems employing force codes. EDSF management acknowledged that an override capability was used to expedite claims processing during a backlog situation. We were told by EDSF managers that the report described in EDSF's technical proposal was not prepared, however. 1/

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[1] The method by which medical services performed in a teaching setting must be billed to Medicare is usually determined by whether reimbursement is made to the hospital or the individual physician. Carriers are required to coordinate with the part A intermediaries in their service area and to insure that any bills received erroneously from teaching physicians or hospitals are denied.

[2] This feature allows data entry personnel to continue entering data into the computer which would otherwise be rejected under the built-in controls or edits designed to assure that only accurate data are entered.

Also, as we reported in December 1980, EDSF's technical proposal stated that its fair hearing officers 2/ would have legal backgrounds and be fully qualified to conduct hearings. EDSF stated

> "Individuals selected as fair hearing officers will be attorneys-at-law, fully qualified to practice law in the state of Illinois. The hearing officers will be qualified to conduct hearings and will either possess a detailed knowledge of or be thoroughly trained in medical terminology and program regulations."

Our review of the resumes and employment applications of EDSF's nine fair hearing officers showed that none were attorneys and only four had college degrees. Further, none of the officers had indicated any experience in Medicare before being hired.

EDSF furnished additional material regarding its hearing staff along with its comments on our draft report. According to EDSF, as of May 1981, its staff of 11 hearing officers consisted of 3 attorneys, 3 individuals with college degrees, and another 5 with claims examination, quality assurance, and supervisory or legal experience.

The backlog problem that we reported on in December 1980 has gotten worse, however. EDSF's volume of pending hearing requests has grown from the 995 cases outstanding as of November 30, 1980, to 1,377 cases pending as of August 31, 1981.

1/In commenting on our report (see p. 139), EDSF stated that the report referenced in its technical proposal has been and is being produced daily; it also submitted an example of a report with its comments. As discussed in more detail on page 140 of appendix V (issue 16), we reviewed this report and the description of it in EDSF's operating manuals. The report referred to by EDSF in its comments is a daily clerk error report which identifies entry errors and the edits involved by clerk number. Although some of these edit error situations are overrideable, the report does not specifically identify these situations, or the edits bypassed. This was confirmed in our discussions with EDSF's director of technical services.

2/Employees of the carrier responsible for conducting formal hearings and rendering reimbursement decisions. A fair hearing is the second stage of Medicare's appeal process.

A COSTLY EXPERIMENT

The Illinois experiment has been costly for all parties concerned. The Government's contract administration costs and benefit overpayments have been excessive. Beneficiaries and providers have had to devote considerable time and effort to obtain satisfactory settlement of their claims. Also, EDSF has spent more to date than it received in contract reimbursements.

Overpayments

Overpayments on claims and the high administrative burden associated with this contract have made it costly to the Government. Based on projections from HCFA's part B quality assurance program, EDSF made payment errors of $67.6 million during the period April 1, 1979, to June 30, 1981. This is about $34 million more than would have been made by EDSF if it had met the contract standard for payment/deductible error rate each quarter. 1/ The $67.6 million includes estimated overpayments of about $29.9 million and underpayments of $30.1 million. It also includes dollar amounts misapplied (either over or under) to the beneficiaries' deductible.

The gross totals of overpayments and underpayments would appear to cancel each other out--but they do not. Both types of errors diminish the program's effectiveness. Also, Medicare's appeal process resulted in adjustments favorable to claimants of $23.8 million, whereas only $2.2 million in overpayments had been corrected as of June 30, 1981. 2/ An estimated $27.7 million in overpayments remains unrecovered. 3/

1/The degree to which EDSF's performance differed from the contract standard each quarter can be seen in appendix II.

2/Some of the payment error corrections applied to errors made by the prior carriers. Also, not all of the corrected underpayments relate to the total amount of underpayments estimated through the quality assurance program because some would not be considered as processing errors but rather adjustments resulting from the receipt of additional information.

3/In commenting on our report (see p. 97), HHS also raised the possibility of large amounts of underpayments remaining unadjusted. It cautioned that, in its opinion, most of the underpayment corrections do not correspond to the underpayments identified through the quality assurance program. Although HHS used a different time period (July 1979 to June 1981), it believed that the correction of underpayments projected through the quality assurance program have amounted to somewhere between $1.4 million and $20.3 million.

We believe that HCFA should analyze the overpayment situations detected through the quality assurance program to determine if some of the incorrect payments can be identified and recovered. Our analysis of some of these situations showed certain commonalities to these overpayments that suggest that further analysis to identify patterns to these errors may identify specific cases. For example, as discussed on page 59, many cases of duplicate payments were made as a result of multiple account numbers for physicians. There have also been many instances of wrong procedure codes being used by data entry personnel that have resulted in duplicate, as well as other incorrect payments. Further HCFA analysis of the quality assurance results could lead to identification and recovery of incorrect payments.

Administrative burden

HHS has had to expend considerable effort and resources in attempting to correct the Medicare problems in Illinois. HCFA has not maintained or developed records of the total cost, although such information would be useful in evaluating the full impact of the Illinois fixed-price contract experiment.

HCFA Region V's contractor review branch has been the principal unit involved in monitoring and administering the Illinois contract. The region's program management division and program integrity office also have had extensive involvement. In addition, the HCFA central office, HHS Inspector General's Office of Audit and Office of Investigations, and the Social Security Administration district offices have all had to work with EDSF on the problems involved in the Illinois contract.

The contract has most heavily affected HCFA's contractor review branch in Region V, which is the focal point for monitoring EDSF's performance. The Illinois contract required more resources than HCFA had available to devote to it, and according to HCFA regional officials, has detracted from HCFA's monitoring of the other contractors in the region. Such attention was necessitated by EDSF's continual unsatisfactory performance. EDSF's inexperience has required that HCFA's staff assist in educating EDSF's staff in Medicare rules and regulations and provide technical guidance for certain functions. HCFA's monitoring has not only provided evaluative data, but also pinpointed operational weaknesses not detected and corrected by EDSF management.

In our December 1980 report, we reported on some critical aspects of EDSF's operations which had been given scant monitoring coverage by HCFA. HCFA responded by creating a special EDSF monitoring unit in February 1981, composed of five full-time Region V contractor review branch employees, to monitor the Illinois contract with the part-time assistance of the branch's computer systems analyst. In contrast, HCFA has 14 staff members to monitor the 18 other contractors in the region.

In addition to the contractor review branch staff assigned to the EDSF contract, staff from the region's program management division and program integrity office have devoted considerable effort to the contract. The program management division has had oversight responsibility for EDSF's handling of congressional inquiries and certain financial functions. After our April 1980 testimony cited a need for improvements in EDSF's beneficiary services, the program management division began making periodic studies, outside of HCFA's conventional monitoring, of EDSF's telephone unit. It also coordinates EDSF's meetings with the Social Security Administration district offices. This division has, as a result of these activities, provided technical direction and pinpointed some operational weaknesses for EDSF, particularly in the handling of beneficiary correspondence and the processing of benefit payments.

The program integrity branch began monitoring EDSF's program integrity operations in the first quarter of 1980. In addition, it has had to devote time to training EDSF staff and is performing some of the program integrity functions EDSF staff cannot handle because of their inexperience.

The Social Security Administration also incurred a great deal of additional work because of the Illinois experiment. Medicare beneficiaries frequently go to Social Security district offices with their Medicare problems. While these offices have been an effective mechanism in identifying problems with EDSF's operations, the staffs were overburdened and frustrated by the multitude of problems they had to deal with. Although this workload seems to have peaked in May 1980, problems affecting the Social Security offices persist.

The biggest burden has fallen on the beneficiaries and providers in Illinois. The magnitude of the incorrect payments, particularly underpayments, indicates the degree of beneficiary and provider dissatisfaction with the program's administration. Additionally, as we reported before, beneficiaries and providers experienced lengthy payment delays and poor responsiveness to their written and telephone inquiries. 1/ EDSF also had numerous problems with its automated correspondence system, which at times generated confusing and incorrect letters. This created additional

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1/During the first 6 months of the contract ended September 30, 1979, the backlog of claims awaiting processing reached a high of 454,000. This inventory represented about 7 weeks work on hand, of which 36 percent was on hand for over 30 days. The claims backlog and high error rate produced a high volume of correspondence from beneficiaries and providers, ultimately leading to a backlog of unanswered correspondence, which by March 1980 had reached about 110,000 letters.

confusion and frustration for the beneficiaries and providers. The persistence of the claimants in Illinois has helped to resolve many of the problems. As noted earlier, Social Security offices have spent considerable efforts working with the claimants to funnel their complaints to EDSF for resolution.

In many cases, however, attempts by beneficiaries and providers to obtain a satisfactory solution to their problems have resulted in a compounding of the errors. HCFA's fourth quarter 1980 monitoring reports showed that 70 percent of EDSF's review determinations were incorrect. The specific findings showed that in some cases payments exceeded the billed amounts, cases that should not have been reviewed were reviewed, and people who were paid correctly once were paid again. HCFA stated it was clear that review determinations were of a much poorer quality than the initial claims determinations.

As EDSF pointed out in its comments on our report (see p. 147), it has improved in this area, although it continues to be below the 90-percent accuracy rate HCFA considers as a satisfactory level of performance. According to the HCFA regional office, EDSF accuracy rates for the quarters ended March 31 and June 30, 1981, were 63 percent and 71 percent, respectively.

EDSF is apparently losing money

EDSF's reported (unaudited) costs during its first 2-1/2 years of operation in Illinois exceeded what it was paid on the contract during that period. A comparison of EDSF's reported costs with the payments under the contract, adjusted for the liquidated damages to be applied, is shown in the following table:

Fiscal year	Contract price	ESDF reported costs	Difference
1978 (4th qtr)	$ 1,254,000	$ 56,154	$ 1,197,846
1979	5,016,000	5,591,192	-575,192
1980	a/4,921,394	14,063,616	-9,142,222
Total	b/$11,191,394	$19,710,962	-$8,519,568

a/Adjusted to include additional postage costs approved by HCFA as a modification to the fixed-price contract.

b/Actual payments were higher, since the entire amount of liquidated damages applicable to fiscal year 1980 was not assessed during the year.

Drawing conclusions from these figures is difficult, however, because the progress payments are not intended to parallel the contractor's pattern of expeditures and thus are not a true accounting measure of revenues accrued by EDSF for the period. An increasingly larger portion of the contract amount is paid in the last years of the contract. In fiscal year 1980, for example, the progress payments are 16 percent of the full contract amount. In contrast, 26 percent of the full contract amount is paid in fiscal year 1983, the final year of the contract.

We believe that EDSF will probably not recover its costs on the Illinois contract unless it obtains increases to its contract price 1/ and can realize extensive reductions in its costs. The uncertainty of the magnitude of these changes, along with the complexity of projecting future workload and the effects of the learning curve on its staff's performance, make estimates of the contract's ultimate financial results difficult. If the figures reported by EDSF are accurate, however, its costs during the 3 years remaining on the contract would have to average half--about $7 million per year--of its fiscal year 1980 costs (depending on the magnitude of any future contract cost modifications) for it to avoid losing money on the contract.

Despite these apparent losses, EDSF has demonstrated the financial commitment to resolving its performance problems.

CONCLUSIONS

The first 2 years of the Illinois Medicare part B fixed-price contracting experiment have been difficult and costly for the beneficiaries, providers, EDSF, and HCFA. EDSF's payment errors from contract inception to June 30, 1981, have exceeded $67.6 million. While overpayments and underpayments have been almost equal, adjustments favorable to claimants, which presumably include underpayments identified through the quality assurance program, have far exceeded overpayment adjustments and an estimated $27.7 million in overpayments remains unrecovered.

Although both EDSF and HCFA are taking action to resolve operating problems, EDSF's performance remains substandard in many areas. Further improvements are needed to assure the proper expenditure of Medicare funds.

1/In fiscal year 1981, EDSF received contract price increases of about $4.5 million, which are not considered in the above table because we assumed they involve some costs outside the scope of the original contract. Further, EDSF had not reported its fiscal year 1981 operating costs to HCFA; the report is not due until December 1981.

RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary of HHS direct HCFA to analyze the large amounts of unrecovered overpayments in Illinois--now estimated to be about $27.7 million. Such an analysis might identify patterns to these overpayments and result in the recovery of some of this money.

HHS COMMENTS

HHS concurred with this recommendation (see p. 90) and said it would make an analysis of the amount of estimated unrecovered overpayments by EDSF, causes of these overpayments, corrective action taken to date, further corrective action needed, and recovery plans.

We have incorporated HHS' major concerns relating to our evaluation of the Illinois experiment in the text of this chapter. (See pp. 53, 59, and 62).

EDSF COMMENTS AND OUR EVALUATION

According to EDSF (see app. V) the deficiencies in this report fall into five major categories:

- --Using selectivity, the report incompletely portrays EDSF's performance.
- --Its discussion of erroneous payments is misleading because it draws no comparison between EDSF errors and those of previous carriers.
- --Its general focus is on transition problems and incorrectly leads the reader to believe they are unique to competitive bidding.
- --It does not adequately use trends to project future results, and it draws questionable conclusions based on isolated time frames.
- --It draws inaccurate conclusions concerning the viability of competitive bidding.

EDSF also proposed four recommendations to be included in our report. These recommendations were the same as EDSF presented on April 28, 1980, in public hearings before the Subcommittee on Health of the House Committee on Ways and Means in Chicago; accordingly, the Subcommittee and HCFA have had an opportunity to consider them. Except for the EDSF proposal for a uniform and universal medical procedure coding system which we have previously recommended, [1] and thus agree with, we do not believe we have done sufficient work on the specific issues either to endorse or disagree with EDSF's proposals.

In support of its criticisms, EDSF identified 23 issues which pertained to specific statements in the draft report or to more broad and substantive issues. These issues and our responses to them are included in appendix V.

A summary of EDSF's comments on the report is provided below.

Using selectivity, the report incompletely portrays EDSF's performance

In support of this criticism, EDSF introduced two criteria for evaluating performance. One is the Contractor Performance Evaluation Program (CPEP), which is applicable to the cost-type part B contractors, effective October 1, 1980. The second is to count the number of elements in the HCFA contract monitoring plan as being met instead of the number of contract standards (see issue 3 on p. 118). EDSF also emphasized the claims and correspondence workload improvement since the heavy backlog periods (Sept. 1979-Mar. 1980).

As a practical matter, we know of no way to completely portray EDSF's performance in Illinois, particularly with respect to the frustration and inconvenience caused Medicare beneficiaries and providers. However, consistent with our evaluation of the other two experimental contractors, we applied the contract standards which all the contractors had bid on and presumably agreed to. Also we included the entire period of EDSF's operations, which included the latest data available (Apr. 1979 to June 1981).

In contrast, EDSF's comparison to the CPEP evaluation criteria was limited to the periods October 1980 to April 1981 for the timeliness of claims processing and January to March 1981 for the quality of claims processing. This approach ignores the first 18 months of EDSF's operations in Illinois. Also, because CPEP is an annual evaluation for which the first evaluations will be applicable for the year ended September 30, 1981, and will not be available until sometime later, it was not possible for us to apply these criteria to EDSF in comparison to other carriers.

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[1] "Attainable Benefits of the Medicaid Management Information System Are Not Being Realized" (HRD-78-151, Sept. 26, 1978).

With respect to using the number of elements in the HCFA contractor monitoring plan as a more representative indication of performance than the contract standards, we cannot agree. For various reasons, about one-third of the individual elements are "deemed met" but were never really evaluated by HCFA, thus distorting the results of an element-by-element pass or fail count. For example, at least 69 of the approximately 212 elements applicable in the quarters ended December 31, 1980, and March 31, 1981, were deemed met without being evaluated. Also, although various elements have different importance in terms of meeting a standard, the EDSF proposed methodology gives all elements the same weight.

In summary, we believe that the criticism of "selectivity" in measuring performance is not appropriate because the principal alternative measure of performance proposed by EDSF does not take into account the entire period of the contractor's operations.

The discussion of erroneous payments is misleading because it draws no comparison between EDSF's errors and those of previous carriers

We have added to appendix II the prior carriers' (Chicago Blue Shield and Continental) average occurrence and payment/deductible error rates for calendar year 1978. Also, to the extent they could be reconstructed from readily available data, we added other comparable statistics for the prior carriers related to the EDSF system I contract standards for claims processed in 15 days or less and for claims pending over 30 days. These data show that EDSF did not begin to compare favorably with the prior carriers for the timeliness standard until the quarter ended September 30, 1980, and for the claims pending and payment/deductible standards until the quarter ended December 31, 1980. For the fourth indicator (occurrence error rate), EDSF has never compared favorably with the prior carriers.

The basic thrust of the EDSF criticism, however, involves its projection of its payment/deductible error rates over the life of the contract ending September 1983 as compared to what the prior carriers' error rates would have been for the same period (issue 2 on p. 116). EDSF concludes that its net overpayment will exceed the prior carriers' projected overpayments by about $6.8 million, which when offset by its administrative cost savings of $20.6 million, produces a net savings of $13.8 million. However, the EDSF projection assumes an average payment/deductible error rate for the period April 1981 through September 1983 of about 1.6 percent. This projected rate is considerably below EDSF's error rates of 2.9 percent for the quarter ended March 31, 1981, and 2.8 percent for the quarter ended June 30, 1981. While such a significant improvement in performance is possible, 1/ we have no basis for making such an assumption and we believe that it is unreasonable to criticize the report as "deficient" on that basis.

Its general focus is on transition-related problems and incorrectly leads the reader to believe they are unique to competitive bidding

Because we believe that the impact of contractor changeover and related transitional problems is the principal concern to be addressed by the experiments in competitive contracting, the scope of our review and the related report did focus on transitional issues. However, we do not mean to imply that such problems are unique to competitive bidding. As we previously reported, although contractor turnover is not necessarily limited to competitive contracts or to HCFA's experimental program, such changes seem more likely in a competitive environment.

It does not adequately use trends to project future results, and it draws questionable conclusions based on isolated time frames

This alleged deficiency in the report apparently refers to two projections (issues 2 and 23) in which EDSF projects savings over the life of the contract. One projection, involving the payment/deductible error rate, was previously discussed. The second projection involves the difference between the prior carriers' and EDSF's experience in denying claims. EDSF projects that its denials, based on billed charges, will be about 3.5 percent higher than the prior carriers, thus resulting in a savings of benefit dollars over the life of the contract of about $150 million.

As discussed in more detail in appendix V (see p. 149), we believe that, based on prior experience, it would be reasonable to assume that over the life of the contract there will be a 2- to 3-percent difference between the gross denial rates experienced by the prior carriers and the higher rates experienced by EDSF. However, there are other differences in experience that should be considered before drawing any conclusions from these numbers.

- --Denials are subject to adjustment if they are later determined to be incorrect or inappropriate. EDSF's reported statistics on reversals favorable to claimants are significantly higher than the comparable statistics for the prior carriers.

1/According to the HCFA quality assurance reports, about one-third of the carriers are operating at that level of error or better.

- --EDSF's error rates were 2 to 3 times higher than the previous carriers during the first year of operation under the experimental contract. Such errors include incorrect denials.

- --There were abnormally high and unexplained increases in claims workload and related billed amounts after EDSF took over Medicare part B in Illinois. Since claim denial statistics are related to the number and types of claims submitted and the related billed amounts, an appropriate methodology for meaningfully comparing claim denial rates from one period to another should consider abnormal variations in billed charges.

In summary, we believe that considering the relatively large differences in the other above-cited experience factors, the projections offered by EDSF are, at best, inconclusive in terms of measuring comparative performance.

It draws inaccurate conclusions concerning the viability of competitive bidding

In support of this criticism, EDSF states that our report concluded that "there is little evidence to support the value of competitive contracting."

We believe that this is an inaccurate and oversimplified statement of our conclusions. As requested, our review focused on three fixed-price experiments for paying claims under part B of Medicare. The objectives of these experiments were to test the viability of this approach in the Medicare contracting environment. Among the factors to be tested were the effects on beneficiary services and the accuracy of benefit payments. Despite the acknowledged savings in administrative costs, the results of these experiments have not demonstrated the viability of this contracting approach in terms of better beneficiary and provider service and more accurate and equitable controls over benefit payments.

CHAPTER 6

A CHANGE TO COMPETITIVE FIXED-PRICE CONTRACTING WOULD BE PREMATURE AT THIS TIME

We have historically supported the use of competitive fixed-price procurement by the Government, where conditions are appropriate. Generally, this type of procurement results in a fair and reasonable price for the Government, and places the greatest risk of performance on the contractor. Because the contractor assumes full responsibility for all costs over the fixed-price, there is incentive for effective cost control.

A change to fixed-price contracting in Medicare would require a change in legislation. Current law provides that HHS enter into cost reimbursement contracts with carriers and intermediaries which result in neither a profit nor a loss from carrying out Medicare activities. As we stated in our June 1979 report on Medicare contracting, a change in the legislative contracting authority may well be the ultimate and most desirable goal for modifying the administrative structure of Medicare. However, we believe such a broad legislative change would be premature at this time because the circumstances and the results of Medicare's three fixed-price experiments in part B have varied, and the experiments are inconclusive as to whether competitive fixed-price contracting can be carried out successfully in Medicare. In addition, the following factors further support our position that such a broad change would be premature.

1. A thorough evaluation of the experiments, such as the one planned by HCFA and discussed on page 15, has not been completed and the results analyzed. Also, HCFA has underway several other contracting initiatives, including experiments involving different types of contractual arrangements and different modes of contractor selection and reimbursement. Little is known about the results of these initiatives.

2. The results of the part B experiments have revealed several weaknesses in the contracting procedures followed by HCFA in these experiments. The contractor selection process and contract design used by HCFA in the experiments were insufficient to assure a smooth transfer of responsibilities between contractors or to safeguard the Government's and the beneficiaries' interests in the Medicare program. Performance and beneficiary services deteriorated to varying degrees during and after contractor changeover, and program payments were not adequately controlled. HCFA has stated that what it learned from these experiences will enable it to more effectively manage future contract initiatives. It has not yet had an opportunity, however, to demonstrate how it can overcome the weaknesses and problems experienced during these experiments.

3. More improvements can be made under existing contracting authority to achieve some of the advantages sought by competitive fixed-price contracting--chiefly, administrative cost savings and fewer contractors. In chapter 2, we discussed the recommendations made in our June 1979 report and the actions taken by HHS to date. Most of these recommendations can be implemented under existing legislative authority to achieve cost savings and higher quality services for beneficiaries and providers.

4. Long-term expectations of cost savings from competitive fixed-price contracting should be viewed with caution. Only the administrative costs (accounting for about 3 percent of program costs) are being competed. Also, where administrative cost savings are realizable, we believe these savings are generally only realizable from the initial contract change, and that recompeting the contracts might not produce additional savings beyond those already realized.

CIRCUMSTANCES AND RESULTS HAVE VARIED

The results of Medicare's three fixed-price experiments have varied. Contractor performance has ranged from satisfactory in the Maine experiment to unsatisfactory in the Illinois experiment. Contractor performance in upstate New York is now considered satisfactory after an initial 6-month period of unsatisfactory performance.

There were different circumstances associated with each experiment that weighed heavily on the results. Although much can be learned from these experiments, we believe they are inconclusive as to whether the broad application of competitive fixed-price contracting in Medicare can produce administrative cost savings without negative effects on program payments and services.

There were many circumstances involved in the Maine experiment that made it different from the other experiments, and may have accounted for the satisfactory results. As discussed in chapter 3, Massachusetts Blue Shield won the Maine contract award with a price that did not represent a significant change from its operating costs in Massachusetts, and actually operated at a higher unit cost than it did under its cost reimbursement contract in Massachusetts.

The Maine experiment involved a relatively small workload area, which was previously serviced by a single contractor, and was taken over by an experienced contractor already processing a much greater workload under a cost reimbursement contract. We believe this dual-contract arrangement allowed Massachusetts Blue Shield the flexibility of placing its more experienced staff on the Maine fixed-price contract. Also in Maine, steps were taken to minimize the differences between the operating methods of the old and new carriers.

The circumstances in the Illinois experiment were different from Maine because of the number of significant changes from the previous carriers' operations. These changes included (1) the introduction of more automation in the reimbursement and correspondence processing systems, (2) a new procedure coding system, and (3) unexplained large increases in workloads.

Another difference in the Illinois experiment was the introduction of a new carrier into the Medicare program. Although EDSF had experience with Medicare data processing, its staff generally had no prior experience managing carrier operations. EDSF's clerical staff also were virtually without any prior Medicare experience.

The circumstances in the New York experiment were different from Maine and Illinois in that an experienced carrier won the contract award, and then moved its base of operations and essentially hired all inexperienced staff. In addition, changes in reimbursement policies were introduced simultaneously to the consolidation of three carrier operations into one.

These differences in the circumstances and results surrounding each experiment make the predictibility of contractor performance under a competitive fixed-price environment uncertain at best.

HCFA'S EVALUATION NOT COMPLETED

In our June 1979 report we did not support a legislative change to permit fixed-price contracting until HHS fully evaluated the experiments and demonstrated to the Congress' satisfaction that no measurable adverse effects will occur. Such an evaluation has not been completed to date.

As discussed in chapter 2 (see p. 15), HCFA awarded a contract in September 1981 for an independent evaluation of the experimental contracts. The scope of work covers all phases of the contract procurements, beginning with the preparation of the RFP through the transition, implementation, and operational phases. The scope is much broader and more complex than the scope of our review of the experiments.

HCFA also has a number of contract initiatives underway that are different from the fixed-price experiments in part B. These initiatives, discussed on pages 16 and 17, involve consolidations of contractor territories and cost reimbursement as well as fixed-price contracts; however, the results of these initiatives are not known.

HCFA has only one competitive experiment underway in part A--a competitively awarded fixed-price contract in Missouri. The experiment was delayed for almost 2 years because of litigation. HCFA estimates that the contract will save about $2 million in administrative costs, but the effects on other program elements, particularly benefit costs, are unknown.

PRESENT CONTRACTOR SELECTION PROCESS DOES NOT ASSURE SELECTION OF A QUALIFIED CONTRACTOR

Based on the three part B experiments, the present contractor selection process in HCFA's experimental program does not assure the selection of a contractor with experienced and qualified staff. As evidenced in Illinois and New York, contractors or their staffs with little or no experience in Medicare may be selected primarily because of their price proposals. In both situations, the clerical work force generally had no Medicare experience. These inexperienced staffs created numerous problems--most significantly, the inaccurate payment of claims. 1/

As we reported in June 1979, as long as price receives a significant weight 2/ in the competitive process, the low bidder will probably win the contract. We were concerned with what lower scores for experience and technical proposals might mean if a contractor wins principally because of a low price offer:

> "There is no problem with such a heavy emphasis on price if all the bidders are equally qualified. Our concern is whether the deficiencies noted by the Bureau's evaluation teams in awarding lower points in the technical and experience categories will have an adverse impact on the program if such bidders win on the basis of lower bids. As previously noted, administrative costs only represent 3 percent of total program costs, and this could be easily overshadowed by increased benefit payments or poor service to the beneficiaries."

In commenting on our report (see p. 98), HHS said it believes "some modifications are essential in the actual contractor selection process to assure that the selected contractor has acceptable Medicare experience and fully understands our obligation to serve the public as efficiently and accurately as possible."

1/In our June 1979 report, we cited similar experiences in CHAMPUS (see p. 9).

2/In the Maine, Illinois, and New York experiments, price received weights of 40, 45, and 50 percent, respectively.

INADEQUATE SAFEGUARDS OVER PROGRAM PAYMENTS AND SERVICES

Neither the procurement process followed by HCFA, the contract documents themselves, nor HCFA's monitoring of the contracts provide adequate safeguards over program payments and services. The contractors' main accountability by virtue of contract penalty provisions is for the contract standards. The contractors are not evaluated or held accountable for carrying out statements or provisions in their technical proposals. The severity of contract penalties also are not proportionate with the risk to the Government and the beneficiaries and providers from inaccurate program payments.

Not accountable for technical proposals

Although contractors may include many important provisions for proper and successful operations in their technical proposals, HCFA does not have adequate assurances these provisions will be carried out. In the Illinois experiment, several commitments made by the contractor in its technical proposal were not carried out. In some cases, HCFA never examined for compliance; in other cases, when noncompliance was discovered, HCFA did not force compliance. (See pp. 59 to 61.)

A related concern is HCFA's inability to make an informed judgment about the quality of potential contractor staffs--both clerical and supervisory. HCFA did not consider the experience of lower level supervisory staff in evaluating technical proposals for the experimental contracts, nor did it give any weight to the fact that some contractors would be using inexperienced clerical staff. In view of the effect inexperienced staff had on services to providers and beneficiaries and on the level of incorrect payments, this is a serious shortcoming. Even though consideration was given to a potential contractor's overall experience, if this contractor plans to move its base of operations (as happened in New York), the vast majority of its staff will be different.

Further, even the key personnel named in the proposals and considered by HCFA in its contract deliberations are not required to actually work on the contract. This deficiency was noted by the HCFA Region V Administrator in his March 19, 1980, report on lessons learned from the Illinois experiment:

> "In scanning the names of the 16 individuals the proposal identified as key management personnel for the Illinois contract, we noted that only three were ever actually involved. The other 13 positions were filled by different individuals. At least in the case of the position entitled Director of Medical Administration, the individual slated would appear to have been much

more qualified than the individual actually hired. The effective performance of this job was critical to a timely, successful procedure code conversion process but the individual holding the job exhibited little knowledge or understanding of the program or of his duties and this contributed in no small part to the complaints we began to receive about the inadequacies of the EDSF procedure coding system. While the individual subsequently terminated his employment (or was terminated), the damage had been done."

HCFA dealt with this latter problem in the recompetition of the Maine contract (see p. 18). The RFP stipulates that changes to key personnel require departmental approval. The penalty for noncompliance is liquidated damages.

Disproportionate risk to the Government

The standards and contract financial penalties are an important aspect of the fixed-price contracts, acting as an incentive for satisfactory performance. However, they do not adequately compensate the Government, or the beneficiaries and providers, for unsatisfactory performance.

In Illinois, where performance has been unsatisfactory for more than 2 years, the contractor has failed 55 of 84 contract standards, 1/ and is subject to $2.9 million in penalties. During this period, however, providers and beneficiaries have suffered unquantifiable hardships, and incorrect program payments estimated at $67.6 million have been made. As discussed on page 62, many adjustments have been made favorable to claimants, but about $27.7 million in estimated overpayments remain outstanding. The $2.9 million in contract penalties hardly compensates for these losses.

In commenting on our report (see p. 97), HHS apparently believed that we attributed EDSF's high error and overpayment rate to the fact that it has a competitive fixed-price contract. This is an incorrect interpretation. We simply stated EDSF's performance results on an experimental fixed-price contract. We do not believe one can totally ignore, however, that many of the factors that contribute to processing errors may have resulted from corporate and agency decisions made in a fixed-price environment, particularly decisions affecting the quality, stability, and size of clerical staff and their supervisors.

1/As noted on page 52, five of the failures are considered tentative and may be reversed if EDSF corrects certain deficiencies.

MORE IMPROVEMENTS CAN BE MADE UNDER EXISTING AUTHORITY

In chapter 2, we discussed many recommendations made in our June 1979 report to the Congress on Medicare contracting. Most of these recommendations--consolidating workloads and eliminating high-cost and poor performing contractors--can be implemented under existing legislative authority and should result in cost savings and higher quality services for beneficiaries and providers.

Although HHS has taken a number of actions in response to these recommendations, we believe more can be done. HHS has also stated in its comments on this report that it has further actions planned. Among the arguments for competitive fixed-price contracting authority is the expected savings from eliminating present high-cost contractors in the program. As discussed in our prior report, we believe this action can be taken under existing authority.

We recognize that the problems we discussed as occurring with contractor turnover may occur with a strong policy of contractor terminations or in consolidating workloads. However, any terminations would be justified by poor performance and would not occur with the regularity that would follow recompeting fixed-price contracts every few years. Further, a consolidation of Medicare workloads should only be undertaken after careful analyses and negotiations identified (1) a more efficient configuration and (2) the contractors with a proven record of good performance, who could most efficiently and effectively handle the larger workloads.

COST SAVINGS FROM COMPETITION

Competition is a key factor in Medicare's fixed-price contracts. While competition can result in some cost reductions, particularly where previous contractors were inefficient, it can also adversely affect beneficiary services and program payments.

A chief argument in favor of fixed-price contracting in Medicare is the potential savings in administrative costs. As we have stated before, the other side of the equation--the benefit payments, which account for 97 percent of the program's costs--deserves the most attention.

In addition to our concern over projecting administrative cost savings without analyzing the effect on total program costs, we believe long-term expectations of competitive fixed-price contracting should be viewed with caution. In theory, competition is expected to assure a fair and reasonable price for the Government. The use of competitive procurement, where conditions are appropriate, should result in the most reasonable costs, prices, and profits in most cases.

We believe that, even where true administrative cost savings are realizable, these savings are generally only realizable from the initial contract change. Although these savings should continue, recompeting the contracts or subsequent contract changes might not produce additional savings beyond those already realized. The administrative cost savings from such contracting principally stem from combinations of several factors, chiefly

--replacing high-cost incumbent contractors with a more efficient contractor,

--consolidating contractor territories or taking other opportunities to create internal economies of scale previously unavailable to the incumbent contractors,

--eliminating or modifying certain contractor functions, and

--contractors lowering their bids to unreasonable levels because of competition, or simply being willing to incur financial losses 1/ during the contract period in order to become a Medicare contractor for the first time, or other longer term objectives.

Whatever the reasons, greater savings might not occur in subsequent contract awards. Once an efficient level is obtained, a new award at the expiration of the contract period might not produce any more savings. 2/ In all likelihood, however, many of the problems with contractor turnover may occur again should a new contractor be selected. Also, to the extent that the initial award went to a contractor whose price was unreasonably low, there is a sort of "false savings" because subsequent awards are likely to produce a bid higher than the previous contract.

In Maine, for example, HCFA recently awarded a new 36-month contract to BSM after recompeting the initial experimental contract. BSM was the low bidder in this procurement, and won with

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1/Often referred to as "buying-in." This concept assumes the contractor knows what is a reasonable bid, but chooses to bid under that and either take a loss or less profit in order to acquire the contract. This underbid may be to compensate for known deficiencies elsewhere in the award process or to gain perceived long-term advantages of having the contract.

2/The savings from eliminating an initial high-cost incumbent carrier would generally always be there, if such a comparison is made. Subsequent recompetitions, in all likelihood, will not produce further savings.

a bid of $9,866,706, including implementation costs. 1/ This price is considerably higher than its contract price of $5,285,000 for the previous 39-month contract (see p. 20), although such a comparison is made difficult by several factors, such as inflation, increases in claim volume, certain changes in the contractor's work requirements, and financial incentive provisions added to the new contract. It appears, however, that little, if any, additional administrative cost savings were realized.

For example, HCFA estimated that it saved $341,400 on the initial experimental Maine contract because the estimated unit price of $2.88 was about $.12 less than the national average for cost-type contracts. Using the same criteria, it could be argued that HCFA lost $2.0 million on the recompetition because the resultant estimated unit price of $3.30 was about $.68 more than the national average for cost contracts. 2/

As previously reported, since the inception of Medicare, total benefit payments have skyrocketed, while increases in intermediary and carrier costs have been more moderate. Further, while the contractors' claim volume has steadily increased, unit costs have steadily decreased. We believe much of this decrease is attributable to increased concern over contractors' administrative costs, followed by HCFA's budgetary control over the cost reimbursement contracts. Any perceptions of Medicare contractors currently receiving "blank checks" are incorrect, in our opinion.

Further, we stated that:

> "A system of strict contract monitoring and budgetary control, followed by a strong policy of contract termination for poor or marginal performers, can introduce many of the advantages of competition into the current Medicare environment and meet the intent of the Congress."

We believe this position is just as valid today.

1/BSM was considered the low bidder only because HCFA chose not to consider implementation costs in its comparison of prices. Blue Shield of Rhode Island's price offer was actually lower than BSM's when comparing total costs.

2/Based on a HCFA estimate of 2,990,000 claims to be processed over the contract's 3 years. In its comments on our report (see p. 98), HHS introduced different criteria for comparing costs and estimating savings. It pointed out that, if only the price paid to the contractor during the operational period is considered (which then ignores over $800,000 paid to the contractor for "implementation" costs) and compared to a "peer group" of contractors' unit costs, then a savings is shown.

CONCLUSIONS

To use competitive fixed-price contracting in the Medicare program, other than through experiments, the Congress would have to provide HHS with authorizing legislation. The results to date from the Medicare part B experiments indicate that administrative cost savings will result initially, but too many problems are associated with other aspects of contractor performance to assure the success of such contracting on a broader scale. The only experiment in part A is just underway.

Since it is not possible to predict what the circumstances would be in a broader application of this contracting strategy in parts A or B, but recognizing what the risks are in terms of program payments and services to beneficiaries and providers, we believe a change in legislative contracting authority would be premature at this time.

HHS COMMENTS AND OUR EVALUATION

HHS does not agree with our conclusions (see pp. 89 and 90), and believes they "place too much emphasis on the Illinois experiment, are premature in light of the limited evaluation methodology used, and do not recognize the valuable experience which has already been gained as a result of" HCFA's contracting initiatives and experimental program. HHS said it learned from the experiences and believes it has already made improvements in carrying out the various aspects of its contracting initiatives. HHS stated that, viewing the Illinois experiment in the context of the other part B experiments and particularly considering the positive experience under the two part A experiments, it believes the experiments have demonstrated that competitive, other-than-cost, contracting can be executed successfully in Medicare and can achieve the goals of quality performance at reduced cost to the Government.

According to HHS, it has carefully analyzed the transition problems experienced in Illinois and believes that future transitions can be managed effectively and that it can minimize disruptions to beneficiaries, providers, and claims processing operations. It stated, moreover, that factors other than the fixed-price competitive nature of the contracts contributed significantly to the problems occurring in the Illinois transition period. It agreed that any transition will involve some disruption and that it is desirable to limit contractor changeover to instances where the potential benefits of quality improvement and cost savings warrant it. HHS pointed out that its May 1981 legislative proposal may have overemphasized formal cyclical competition of contracts on a national basis.

Our conclusions are based on the results to date of the three part B experiments. We acknowledge that our concerns about the potential impact of competitive fixed-price contracting in Medicare are heavily influenced by the negative aspects of the Illinois experiment. As we previously pointed out, the negative aspects--poor service to providers and beneficiaries and inaccurate program payments--can overshadow the positive aspects of administrative cost savings.

HHS has learned from these experiments and will probably learn more when a thorough evaluation, such as the one planned by HCFA and described on page 15, is completed. Our review, however, does not lead us to conclude that HHS can carry out its planned contracting initiatives with the success it describes in its comments. On the other hand, we do not have a closed mind on the competitive fixed-price contracting issue. If and when a competitive fixed-price procurement approach can be designed and implemented which assures a consistently acceptable or improved level of performance, particularly in terms of beneficiary and provider services and accuracy of program payments, we would be willing to reexamine this issue.

Other comments made by HHS are incorporated in the text of this chapter (see pp. 77 and 80).

OTHER COMMENTS

The Health Insurance Association of America and the Blue Cross and Blue Shield Associations commented on our report (see apps. VI and VII) in letters dated August 12 and 18, 1981, respectively.

The Blue Cross and Blue Shield Associations stated that the report deals with most, if not all, of the concerns the Associations had raised in the past concerning the potential impact of competitive bidding. It had no recommendations to make concerning the report.

It presented its opinion, however, that the "procurement technique" used in the experiments is not well suited to the nature and goals of the Medicare program. In its opinion,

> "A true validation of this technique would require more than one bid and award in a given area. This does not seem to have been contemplated by the HCFA experimental contracts. While this would be impractical at this late hour in at least some of the cases and would run contrary to the advice inherent in your report, it nevertheless suggests to us that the opportunity for true experimentation with this approach has always been problematic. In any event, before the Government seriously considers the approach as permanent Medicare policy, there should be far more evidence of success than is so far available."

The Health Insurance Association of America, on behalf of the 11 commercial insurance companies in Medicare, stated that our conclusions supported the Association's belief that contracting for Medicare administration on a competitive fixed-price basis is not sound policy. It stated that "proper management of the cost contracting process can, and does, provide incentives to innovate, to process claims timely on a quality basis, and effectively control program costs."

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EX OFFICIO:
AL ULLMAN, OREG.
BARBER B. CONABLE, JR., N.Y.

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

SUBCOMMITTEE ON HEALTH

NINETY-SIXTH CONGRESS

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COMMITTEE ON WAYS AND MEANS

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J. P. BAKER, ASSISTANT CHIEF COUNSEL
JOHN K. MEAGHER, MINORITY COUNSEL

SUBCOMMITTEE STAFF
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IRWIN HYTNER
JOHN L. S. HOLLOMAN, JR., M.D.

January 15, 1980

The Honorable Elmer B. Staats
Comptroller General
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Staats:

In your report to the Congress of June 29, 1979, entitled "More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing" (HRD-79-76), you expressed some concerns about the potential impact of competitive fixed-price contracting on the medicare program. Your report suggested that the Department's current experimental fixed-price program in medicare should be subjected to further intensive evaluation before any significant legislative changes are made in the medicare contracting provisions. Although the contracting experiment in Maine appears to have worked well, you warned that the New York and Illinois experiments provided a greater potential for problems to develop.

As you know, several problems have indeed developed in Illinois. Since beginning operations in April 1, 1979, Electronic Data Systems Federal Corporation (EDSF) has experienced numerous performance problems. There have been major disruptions in services to beneficiaries and providers in Illinois, a much higher degree of inaccuracy in processing and paying claims than anticipated, and a lack of responsiveness to public and congressional inquiries. Since the Subcommittee shares the concerns which you raised in your report, as well as some more immediate concerns about the current status of the Illinois experiment which have been expressed to me by members of the Illinois congressional delegation, I believe it would be desirable for the Subcommittee to undertake a more thorough examination of the experiment.

The Health Care Financing Administration and its Chicago regional office are currently monitoring EDSF's performance. I have requested the Administrator of HCFA to keep the Subcommittee fully informed about the results of these monitoring activities, and I will be requesting him to provide the same information to your office. Although many of the problems experienced to date may be characterized as "transitional" and are likely to be resolved over time, the Subcommittee remains concerned about the implications of such contracting problems for the effective administration of the medicare program.

The Subcommittee has decided, therefore, to hold hearings in the near future on the issue of medicare contracting for claims processing during which we expect to conduct an indepth examination of the Illinois experiment. Our present plan is to hold hearings in Chicago on the Illinois experiment in April 1980, followed by hearings in May on the broader issue of medicare contracting.

In anticipation of these hearings, I am requesting that GAO evaluate the experimental fixed-price contracts in medicare as a follow-up to the June 1979 report, with specific emphasis on an investigation of EDSF's performance in Illinois. Such an evaluation should also address HCFA's progress in implementing contractor performance standards and its progress in carrying out other recommendations contained in your June report. It is my intent to request GAO testimony at both the Illinois and the broader contracting policy hearings.

Sincerely yours,

Charles B. Rangel
Chairman

CBR/hl

ELECTRONIC DATA SYSTEMS FEDERAL CORPORATION QUARTERLY PERFORMANCE RESULTS IN ILLINOIS FROM APRIL 1, 1979, TO JUNE 30, 1981

System One standards	EDSF performance quarter ended								
	6/30/79 (note a)	9/30/79 (note a)	12/31/79	3/31/80	6/30/80	9/30/80	12/31/80	3/31/81	6/30/81
1. 75 percent of claims must be processed in 15 days or less (percent) (note b) [76.2, 77.9] (note c)	44.5	39.1	37.6	46.6	67.0	81.6	84.5	d/68.1	73.0
2. No more than 12 percent of claims pending at end of month can be over 30 days old (percent) [7.8, 9.2] (note c)	31.1	27.6	50.0	23.2	25.6	20.7	10.4	10.3	13.7
3. Occurrence error rate must be less than the median of all other carriers	34.7	32.5	25.6	27.0	23.1	19.3	20.3	18.8	16.6
Median [13.3, 11.0] (note c)	(8.5)	(8.0)	(9.3)	(8.6)	(8.7)	(9.9)	(7.9)	(8.0)	(7.0)
4. Payment/deductible error rate must be less than the median of all other carriers	8.1	6.6	5.8	5.3	4.2	3.6	2.7	2.9	2.8
Median [2.4, 2.8] (note c)	(2.0)	(2.2)	(2.5)	(2.3)	(2.0)	(2.5)	(1.8)	(1.9)	(1.7)
5. Average processing time for informal reviews must be 25 days or less (days) [N/A] (note c)	28.2	21.5	63.2	82.5	50.4	47.1	52.4	68.6	35.0

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System Two standards	EDSF performance quarter ended								
	6/30/79 (note a)	9/30/79 (note a)	12/31/79	3/31/80	6/30/80	9/30/80	12/31/80	3/31/81	6/30/81
1. Claims process	-	-	failed	failed	failed	failed	failed	e/failed	e/failed
2. Coverage and utilization safeguards	-	-	failed	failed	failed	failed	failed	e/failed	e/failed
3. Program reimbursement	-	-	passed	passed	passed	passed	passed	passed	passed
4. Electronic data processing operations	-	-	passed	passed	passed	passed	passed	passed	passed
5. Beneficiary services and professional relations	-	-	failed	failed	failed	failed	failed	failed	e/failed
6. Program integrity	-	-	passed	failed	failed	failed	failed	passed	passed
7. Quality assurance	-	-	passed	passed	passed	passed	passed	passed	passed
Number of standards passed	-	-	4	3	3	4	5	6	4
Number of standards failed	-	-	8	9	9	8	7	e/6	e/8
Cumulative liquidated damages (millions)	-	-	$.2	$.9	$1.4	$1.8	$2.1	$2.5	$2.9

a/Standards were not applicable for assessment of liquidated damages until quarter ended December 31, 1979. Also, EDSF's performance relative to the System Two standards was not evaluated until the same quarter.

b/Standard is 70 percent for quarters ended March 31.

c/Prior carriers' (Chicago Blue Shield and Continental, respectively) performance statistics for calender year 1978; N/A is not available.

d/Although EDSF's performance was below the standard, HCFA has deemed this standard passed because of problems with the Social Security Administration's computer system that adversely affected EDSF's processing timeliness.

e/Tentative results for System Two standards. EDSF has an opportunity to correct deficiencies.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General
Washington, D.C. 20201

2 8 AUG 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "The Success of Competitive Fixed-Price Contracting in Medicare Has Not Been Demonstrated by Existing Experiments." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Eileen Boyd fa
Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report Entitled, "The Success of Competitive Fixed-Price Contracting in Medicare Has Not Been Demonstrated by Existing Experiments"

Overview

The General Accounting Office (GAO) conducted this audit to: (1) review the progress we have made in implementing the recommendations in the June 1979 report,1/ and (2) evaluate the performance of the three Part B experimental fixed-price contractors, with special emphasis on the performance of Electronic Data Systems Federal Corporation (EDSF) in Illinois.

We have carefully reviewed the draft report as part of our evaluation of our experimental contracting program and our overall efforts to achieve greater effectiveness and efficiency in the administration of the Medicare program. Some of the findings in the draft report parallel the results of our own analysis. Thus, the report can be useful in providing support to our efforts to update and refine our initiatives to improve Medicare contract administration. However, we believe that the draft report would be improved if the following issues were considered. First, the draft report does not give sufficient attention to the fact that we have vigorously pursued the recommendations in the June 1979 GAO report. Second, the report does not address or recognize the overall scope of our initiatives to introduce improved methods and techniques in Medicare contract administration and thus tends to view the competitive fixed price experiments out of context. GAO has concluded that cost reimbursement contracts are presently more effective for Medicare Part B; that Medicare's experiments have not demonstrated that competitive fixed-price contracting is desirable; and, that the Congress should not provide the Department with the authority to expand this type of contracting on a large scale. We believe these conclusions place too much emphasis on the Illinois experiment, are premature in light of the limited evaluation methodology used, and do not recognize the valuable experience which has already been gained as a result of our contracting initiatives and experimental program. Each of these concerns is addressed in more detail below.

We believe that our efforts to improve Medicare administration under current law, as well as our experience with our experimental contracts, have demonstrated the benefits which can be derived from introducing greater competition into the contractor selection process and allowing reimbursement of contractors on an other-than-cost basis with liquidated damages and incentive payments to encourage quality performance. We firmly believe that the experiments have been highly productive in assisting us in developing

1/ "More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing" (HRD 79-76).

new approaches to Medicare contract administration which may result in substantial long range benefits to the program. However, based on our evaluation of our experience during the past several years, we agree that our May 1981 legislative proposal may have overemphasized formal cyclical competition of contracts on a national basis.

We have under consideration a number of proposals which would provide the Secretary with greater flexibility to select and reimburse Medicare contractors. We hope to take advantage of the substantial benefits in the quality and cost effectiveness of program administration which can be achieved in a more competitive other-than-cost contract environment without the disadvantages which could result from the possibility of frequent contractor turnover where this would not produce appropriate benefits. The President's Management Improvement Council's (a Blue Ribbon Panel established by the previous administration) May 1980 "Report on Medicare Contracting" strongly supported legislative authority to provide for the use of competitive selection, to eliminate the nomination process in Part A, and to permit flexibility in contract pricing arrangements at the discretion of the Secretary. In developing a proposal we will be considering the PMIC's recommendations. We urge GAO to reserve its conclusions until such time as we have had an opportunity to fully staff out this issue.

Recommendation to the Secretary of HHS

That the Secretary of HHS direct HCFA to analyze the large amounts of unrecovered overpayments in Illinois--now estimated to be about $25 million. Such an analysis might identify patterns to these overpayments and result in the recovery of some of this money.

Department Comment

We concur. We have concerns, however, with the methodology used by GAO to develop the $25 million estimate of unrecovered overpayments; these concerns are discussed in the supplementary comments below. We will conduct an analysis of the projected overpayments to identify patterns, prevent future overpayments, and maximize recovery of monies where this is feasible and cost effective. Some of this analysis of the causes of overpayments is already being conducted on an ongoing basis by Health Care Financing Administration (HCFA) and the contractor as part of the quality assurance program which produced the error rates used in the GAO projections. The information obtained from such analyses is used by HCFA and the contractor to identify changes needed in the contractor's procedures to prevent future overpayments. The steady reduction in EDSF's payment deductible error rate is evidence of the effective use of the analysis of the overpayments to improve performance. In addition to this ongoing analysis, HCFA will prepare a special analysis of the amount of estimated unrecovered overpayments by EDSF, causes of these overpayments, corrective action taken to date, further corrective action needed, and recovery plans.

Supplementary Comments

Progress Since GAO's June 1979 Report and Recommendations for Achieving Greater Efficiency in Medicare Contract Administration

The draft report assesses the progress that has been made since the June 1979 report. However we note the report does not recognize the substantial degree of progress that has actually been achieved. Major strides have been made with respect to all of the previous recommendations in both the experimental area and the area of administrative initiatives under current law.

The June 1979 GAO report made a number of recommendations to the Secretary which addressed: establishment of performance standards, implementation of a firm policy of termination for poor performers, reduction in the number of poor performers, experimentation to evaluate the feasibility of merging Part A and Part B administration and an integrated software system, experimentation with performance incentive contracts, and evaluation of current experimental contracts.

We have implemented performance standards in both Part A and Part B as well as in all of the experimental contracts, and have taken vigorous administrative action to remove poorly performing contractors and to reduce the overall number of contractors through nonrenewal of contracts or voluntary consolidations. These actions are discussed on pages 24-25 of the draft report but are characterized as only "some progress". We believe we have accomplished a great deal. Since 1979, the number of contractors has been reduced from 123 (46 Part B carriers, 77 Part A intermediaries) to 109 (41 Part B carriers and 68 Part A intermediaries). We will soon take action to reassign free-standing home health agencies (HHAs) to a single intermediary in a geographical region, thus reducing the number of intermediaries serving this class of providers from 70 to 50. We also have continued with our experimental plans for testing different modes of contractor selection and reimbursement, including experimentation with contracts with performance incentives in New York (Part A) and Maine (Part B). With respect to experimentation with merging Part A and B administration, we have initiated a procurement for a combined A/B contract in Colorado, Wyoming and Utah; however, litigation has delayed implementation of this experiment. We are also testing the value of integrated A/B software systems by allowing a limited number of cost contractors to procure integrated A/B claims processing systems and participate with us in evaluating these systems.

We are carrying out a continuous program of monitoring and evaluating the existing experiments, and using the "lessons learned" in designing new experiments (such as the recent recompetition of the Maine contract) and current law initiatives. In addition, we plan to award a contract soon for a formal evaluation by an outside consultant of the experimental contracts in Maine, Illinois and Upstate New York to supplement our ongoing operational evaluations. The draft GAO report notes that the scope of work which will be undertaken as part of this evaluation is much broader and complex than that undertaken by GAO in its review of the experiments and will entail further development of their lines of investigation including contractor selection, experimental design, monitoring, costs of implementation, and impact on benefit costs. We would hope that GAO could provide more positive recognition of the achievements to date.

In addition, we agree that substantial savings can be realized by transferring the Railroad Retirement Board (RRB) Medicare workload to local Medicare carriers.

Overall Medicare Contracting Initiatives

The draft GAO report could be strengthened by explaining the role of the experimental contracting program within the context of our overall Medicare contracting initiative. As a result of various studies (including the 1979 GAO report) there have been recommendations about improvements needed in the original Medicare noncompetitive cost-based contracting structure. We have been implementing these recommendations for the past several years to bring about changes in the Medicare contracting environment. Our goal is to create an operating framework which is more conducive to improving the quality of service to providers and beneficiaries at reduced cost to the Government. The major elements of this initiative include reduction in the number of contractors (including combining administration of Parts A and B where this is effective), vigorous application of contractual standards of performance, and movement away from the current noncompetitive cost-reimbursement contracts. Our initiatives include administrative actions under current law, a demonstration program of contracting experiments, as well as a legislative proposal for greater contracting flexibility. This encompasses all of the elements of the "tripartite strategy" recommended in the June 1979 GAO report and referenced again on page 7 of the current draft report.

The experimental program we are pursuing as part of this overall Medicare contracting initiative is designed to test various types of contracting mechanisms in different States to identify the most effective ways to accomplish our long-range objective of being able to use more flexible contracting arrangements than the non-competitive cost contracts provided for in the existing statute. Our aims have been to test the optimum contractor workload, the various means of selecting and reimbursing contractors, the most appropriate methods of measuring and influencing contractor performance, and the mechanisms needed to effect a smooth transition from one contractor to another to the extent that changes in incumbents may be needed to accomplish our objectives. The Maine, Illinois, and upstate New York Part B experimental contracts reviewed in the draft GAO report are the first in a series of demonstrations planned to test these various aspects of contracting.

In evaluating the three Part B experiments, the draft GAO report should recognize the above described role of the experiments in our overall Medicare contracting initiative. The draft report should also recognize that experiments are carried out to learn, and sometimes the most valuable learning takes place when problems arise. We believe that the lessons learned thus far from our experiments about the mechanisms needed to effectively execute various types of contractual arrangements have been invaluable in assisting us in designing and carrying out future contracting efforts. We have already used the results of the experiments to our advantage in structuring the recompetition of the Maine experimental contract and in implementing the nonrenewals, transitions, and consolidations we have been pursuing with the cost contractors. Thus, in this respect the experiments have made a very positive contribution.

In evaluating whether the three Part B experiments have been successful in demonstrating that competitive other-than-cost contracting can achieve the goals of improved quality of performance at reduced cost to the Government, we do not agree with the GAO draft reports's conclusion that "the results of the experiments have not clearly demonstrated that competitive fixed-price contracting will work successfully in Medicare." We believe that in arriving at this conclusion GAO has placed too much weight on the Illinois experiment and does not provide a balanced evaluation of the three experiments. As the draft GAO report admits, two of the three experiments have run smoothly, have resulted in satisfactory performance which exceeds that of comparable cost contractors in many cases, and have resulted in cost savings. We agree that the Illinois experiment has involved a number of problems. However, we believe that the chapter in the draft GAO report on Illinois does not provide sufficient detail about the causes of the problems. For example, the report does not mention the adverse effects of EDSF's decision to locate in Des Plaines and the setbacks resulting from having to start over in Marion and Springfield. Providing this type of background would improve the draft GAO report by providing more context in understanding how the Illinois experiment has progressed. We also believe that the draft GAO report places too much emphasis on the competitive fixed-price variable as the cause of problems when, in reality, there have been a number of other variables in each of the experimental contracting environments, and we believe these have been, in many instances, primarily responsible for implementation difficulties.

With respect to Illinois, as the draft GAO report points out, EDSF's performance has been improving over the term of the contract and in some areas now exceeds that of current cost contractors and the former carriers in Illinois. We are currently completing a comprehensive evaluation of EDSF's performance through the June 1981 quarter to assess the degree of progress and whether continuation or modification of the contract is warranted. This evaluation is expected to be completed by October 1981.

If the Illinois experiment is viewed in the context of the other Part B experiments and particularly if the positive experience under the two Part A experiments is considered, we believe that the experiments have demonstrated that competitive other-than-cost contracting can be executed successfully in the Medicare program and can achieve the goals of quality performance at reduced cost to the Government. However, we agree with the draft GAO report that the experiments have pointed up certain problem areas in implementation. As indicated above, we have learned from our experience and believe that we have already made improvements in carrying out the various aspects of our contracting initiatives.

The draft GAO report identified several specific implementation problems which have occurred in the three experiments. We would like to make the following comments on these areas.

With respect to transition problems, we concur with the GAO draft report that smooth transitions are important and that effective management of transitions is a complex task. Transitions can be managed effectively in the competitive fixed-price environment as the draft GAO report concludes with respect to the Maine and upstate New York experiments; the transitions in the Part A New York and Missouri experiments have also been smooth. Moreover, where problems have occurred in the transition period, we believe that variables other than the fixed price competitive nature of the contracts have played a major role. For example, the Illinois experiment involved a number of elements of "change" in addition to changing from a cost to a fixed price contractor: merging of two contractor areas, creation of one of the largest carrier workloads in the country, change in contractor location, procedure code conversion, and the introduction of a new non-health insurer carrier. We believe that each of these factors contributed significantly to the transition problems. We believe that similar problems could have occurred if the transition had occurred in the non-competitive cost environment. Change from one cost reimbursement contractor to another cost reimbursement contractor may in some instances be accompanied by disruption, especially if the incumbent leaves involuntarily. This should be taken into account.

We have carefully analyzed the transition problems experienced in Illinois with a view toward building safeguards into our management of future potential contractor changeovers to prevent similar problems.

A number of these elements were built into the recompetition process for the Maine contract and have been used in managing the transitions and consolidations we are undertaking with our cost contractors. We believe that transitions can be managed effectively and that we have developed experience and techniques to keep disruptions to beneficiaries, providers, and claims processing operations to a minimum in future transitions.

We agree that any transition will involve some degree of disruption and that it is desirable to limit contractor changeover to those instances where the benefits in terms of prospects of quality improvement and cost savings warrant it. However, the draft GAO report comes close to proposing that all other considerations be sacrificed to smoothness in transition. By recommending that changes be severely limited, and never be undertaken in a competitive other-than-cost environment, in order to achieve this smoothness, GAO would, we believe, unnecessarily limit improvement in Medicare administration. Without change there is unlikely to be improvement in service or cost reduction, and with change there may be some disruption. The better course of action, we believe, is to carefully select the situations in which contractor turnover is appropriate and to plan for and manage the transition effectively. We are taking steps to achieve this in our contracting program, and believe that transitions can be effectively accomplished in other than non-competitive cost environments.

Another implementation problem cited in the draft GAO report involves procedure code conversions. We agree that procedure code conversions can be difficult. For this reason, we are currently testing a prototype uniform coding system based on CPT-4. If the test proves this coding system to be effective, we plan to require its implementation by all Medicare Part B carriers nationally. After this one-time conversion to the new uniform coding system, procedure code conversions would no longer be required during the transition from one carrier to another since the new carrier could simply take over the old carrier's reasonable charge files and pricing procedures.

Another problem cited in the draft GAO report involves the contractor selection process. GAO is concerned that the contractor selection process used in the competitive fixed price experiments does not assure selection of a qualified contractor. In the experiments, we have been testing various weights to the three elements of price, technical proposal, and experience which are considered in the contractor selection process. This will be reviewed in our formal evaluation of the experiments. In the recent recompetition of the Maine contract, we added elements to the RFP to require Departmental approval of changes in key technical personnel included in the proposal to prevent one of the problems cited by GAO in the Illinois experiment. We agree that the contractor selection process needs to be designed carefully to assure selection of qualified organizations. As a result of our experiments, we are learning and will continue to learn about the most effective methods of contractor selection.

Another issue raised in the draft GAO report concerns the adequacy of safeguards over program payments. We agree with the importance of assuring adequate control of program payments in the fixed-price contract. For this reason, we have built into the contractual performance standards provision for liquidated damages if the contractor's claims processing error rates are not better than 50 percent (60 percent in one contract) of the other contractors in the country. We also have established a number of other performance standards in specific functional areas of operations designed to safeguard the accuracy of program payments; the contractors are also liable for monetary damages for failure to meet these standards.

GAO is concerned that monitoring the fixed price contractor's performance primarily in terms of these contractual performance standards does not adequately safeguard program payment. We wish to point out that the performance standards were developed in an effort to quantify performance levels in those areas of contractor performance requirements considered to be most important in terms of measuring the quality of their operations and adherence to program requirements. At the time the three Part B fixed price contracts reviewed by GAO were executed, there were no national quantified Part B performance standards. Therefore, performance standards were specially designed for each contract as part of the experiment. We now have national quantified formal performance standards for cost contractors under both Part A and Part B. As we award new other-than-cost contracts (e.g., Missouri and Maine), we are using this national performance standard measuring system as the contractual tool for evaluating performance, and experimenting with the specific levels of performance which should trigger liquidated damages or incentive payments. This national contractor performance standards package includes an element which requires compliance with all other operating procedures not otherwise specifically measured in the standards. Thus, by using the national performance standards in all new other-than-cost contracts, we are addressing the GAO's concern about operational requirements for which a specific performance standard is not included in the contract. Even for the existing fixed price contracts, the regional office monitors performance outside of the scope of the contractual performance standards through the day-to-day surveillance by on-site Federal staff as well as by special review of potential problem areas.

With respect to the draft report's concern about the unrecovered overpayments which GAO estimates have been made in Illinois by EDSF, we too are interested in assuring the accuracy of program payments. In that regard, we are analyzing the overpayments to identify patterns, prevent future overpayments, and maximize recovery. However, we believe that the methodology GAO has used to project a $25 million unrecovered overpayment may have resulted in an overestimate.

The GAO draft report discusses on page 90 projections from the Health Care Financing Administration Part B Quality Assurance (QA) program for "the 2-year period April 1, 1979 to March 31, 1980" of $60.4 million in payment errors. To begin with, these dates represent a 1-year period. In addition, for the 2-year period April 1979 to March 1981 the combined HCFA QA estimate for over and underpayment errors for EDSF was $53.2 million. Further, when discussing projections, it is important to take into account the reliability of the estimates. For example, in applying a standard

95 percent confidence level (i.e., ± 2 standard errors) to April 1979-March 1981, we have found that EDSF's estimated overpayment error could be as low as $22.5 million, while their underpayment error could be as high as $31.0 million.

The draft GAO report does not say from what source document they calculated the $20.3 million in underpayments paid out and $1.8 million overpayments recouped. In reviewing EDSF's appeals report (SSA-2590) over the last eight quarters (July 1979-June 1981) we have found that more than $22.3 million has been paid out as a result of reviews and hearings and only $1.4 million has been paid to beneficiaries and suppliers as a result of reopenings and revisions. In our opinion the QA error type situations are identified more through the reopenings and revisions, while other substantive issues (e.g., medical necessity) are identified through reviews and hearings. This fact is highlighted by GAO on page 90 of the draft report in footnote 2. The report states that "not all of the corrected underpayments relate to the total amount of underpayments estimated through the quality assurance program because some would not be considered as processing errors but rather adjustments resulting from the receipt of additional information." Consequently, we believe all that can be stated with certainty is the underpayment payout is somewhere between $1.4 million and $20.3 million.

In addition, we have made some comparisons between the outgoing carriers and EDSF with respect to rates of overpayments detected (on HCFA-2174) to overpayments projected on the QA report and rates of underpayments reported as revisions (on SSA-2590) to underpayments projected on the QA report. In calculating the above, we found that EDSF compared favorably with both Illinois Blue Shield and Continental Casualty (the predecessor contractors) with respect to the percent of overpayments detected. EDSF at 14.0 percent fell between Continental Casualty at 16.0 percent and Illinois Blue Shield at 10.0 percent. On the other hand, in looking at rates of underpayments reported to those projected through QA findings, EDSF appears to be much more efficient in this area with 19.0 percent detected as compared to 3.0 percent for both Illinois Blue Shield and Continental Casualty.

Finally, GAO implies that the EDSF high error and overpayment rate is attributable to the fact that it is the holder of a competitive fixed-price contract. It should be noted that since 1976 there have been cost contractors with payment deductible error rates which exceed that of EDSF. Accordingly, the fact that a fixed-price contractor has had high error rates does not warrant the conclusion that a contracting initiative which would encourage more competition in the selection of contractors on an other than cost basis is flawed.

GAO is construing the lack of total documentation and the failure of the HCFA regional office (RO) to write a report on the EDSF transition and implementation to mean the RO's monitoring of the transition was limited. On the contrary, the RO made a conscious decision to devote substantial staff time to assist the contractor instead of preparing reports. The actual transition and implementation activities were patterned after those followed in Maine. The RO devoted about 4.5 person years to the transition and participated in the transition activities/tasks outlined in EDSF's proposal.

During the early operational stages for Cook County (April 1, 1979 on), the RO was present at EDSF almost daily to identify and solve operational problems. It is true that transition activities were less intense for the Continental Casualty workload during the April 1, 1979 through June 30, 1979 period. This might have led to some minor failures in early identification of problems. However, certain patterns and trends particularly in beneficiary services did not become apparent until after the Continental Casualty workload was assumed.

The draft GAO report also questions the extent of administrative cost savings which can be achieved through the competitive fixed-price contracts. The report concludes that recompetition in an area will not cause major price reductions and cites the Maine recompetition as an example, comparing the price of the winning contractor to the national average unit cost for FY 1980. Actually, if the projected operational unit price of the selected contractor ($3.03) is compared to the FY 1980 average unit cost of its "peer group" of contractors with similar-sized workload ($3.10), a savings is shown. On the general issue, however, we agree that, once an efficient level is obtained, it is unlikely that recompetition will produce the substantial administrative cost reductions realized by the initial competition. However, since it is understood that recompetitions will occur periodically, there will be competitive pressure on the contractors to be cost effective. The savings then will be evident in lower rates of cost increases.

In weighing all factors, we believe that the introduction of new initiatives and methods in the procurement process for selecting contractors, with reimbursement on a cost and other than a cost basis, are viable and equitable approaches for all parties. Because of the lessons learned, during our experiments, we believe that some modifications are essential in the actual contractor selection process to assure that the selected contractor has acceptable Medicare experience and fully understands our obligation to serve the public as efficiently and accurately as possible.

Blue Shield
of Western New York, Inc.

298 Main St. Buffalo N.Y. 14202
(716) 849-6981

JOHN T. MANYON, C.F.A.
PRESIDENT

August 19, 1981

United States General Accounting Office
Human Resources Division
441 G. Street, N.W.
Washington, DC 20458

Attention: Gregory J. Ahart, Director

Dear Mr. Ahart:

This letter is in response to your July 21, 1981 letter seeking comments on the GAO draft report ("Report") regarding fixed-price Medicare contracting experiments in Maine, Illinois and Upstate New York. We have limited our comments to certain major discrepancies in the Report insofar as they relate to Blue Shield of Western New York, Inc., ("BSWNY").

The "Cover Summary" states that "contractor performance has ranged from satisfactory in the Maine experiment to unsatisfactory in the Illinois experiment". This implies that BSWNY's performance, unlike that of Massachusetts Blue Shield, has been less than satisfactory. This implication is not supported by any information available to us and is contradicted by facts contained in the Report. Indeed, the facts contained in the Report suggest a contrary conclusion - that BSWNY's performance has exceeded even that of Maine for a number of reasons. First, BSWNY has saved the Government significantly more money on a proportionate basis in both administrative and benefit costs than has been achieved in Maine. Second, despite some initial difficulties which resulted from factors beyond BSWNY's control, HCFA now considers BSWNY an above-average performer. In fact, our processing time and error rates are not only significantly better than those of previous carriers in Upstate New York, but they also rank us among the best performers nationally. Third, the report recognizes that, of Monitoring Plan Standards evaluated, Maine passed 136 of 144 Standards and BSWNY passed 57 of 60 Standards. Thus, although the two carriers' performances, viewed from this standpoint, are close, it appears that BSWNY's is better than that of Maine, notwithstanding the fact that Maine did not encounter anywhere near the changeover difficulties that BSWNY successfully overcame and BSWNY did not have the benefit of the consistency approach used in Maine.

Some dislocations are unavoidable and predictable with any change of carriers especially when combined with other changes such as integration of previously separate territories. The Report's characterization of BSWNY's consolidation of operations as a "shaky start" unfairly casts BSWNY in an unfavorable light. The so-called "shaky start" really refers to the time that BSWNY successfully overcame a number of predictable and also several not foreseeable problems such as:

(1) the mandated specialty merger with its unanticipated reimbursement rollback;

(2) defective information received from an incumbent carrier;

(3) sharp differences in medical policy of incumbent, some of which appeared to be inconsistent with applicable Medicare regulations;*

(4) a large claims backlog from incumbents (14,683 claims from Rochester, 75% of which were non-assigned, and 102,471, claims from Metropolitan - as opposed to the 69,528 stated in the Report);

(5) a bias in the RFP in the first months of operation for quantitative rather than qualitative achievement, and,

*The Report does not reflect the gravity or the impact of the specialty merger problem, the problems created by the differences in medical policy and the inadequacy of the provider information BSWNY received. BSWNY previously attempted to summarize the impact of these factors in a letter to Mildred L. Tyssowski, a copy of which is enclosed.

(6) substantial wide-open adverse publicity that prejudiced the beneficiary and provider communities against BSWNY and the consolidation of the three former Upstate New York Medicare territories.

In the discussion regarding contractor selection (commencing on page 48), the Report emphasizes that, among bidders for the Upstate New York contract, BSWNY finished 4th in experience. A reader not thoroughly familiar with ACERs and all relevant evaluation components would be likely to conclude that BSWNY lacked experience necessary to administer the Medicare Part B Program in Upstate New York. The fact is that BSWNY's experience was equal to or superior to that of all other bidders in its accuracy in processing claims and its timeliness of claims payments. These obviously are critical qualifications for any performance evaluation.

BSWNY's major "shortcoming" was that the ACERs catagorized BSWNY's per-claim costs as higher than some other carriers'. Not only is this "shortcoming" irrevelant in a fixed-price contract experiment, but it was incorrect because it was depending on the number of "claims" count, and different carriers have different definitions of what constitutes a "claim". Even the Report concedes (page 30) that the GAO knew that HCFA was aware that "claims count is subject to manipulation". The second "shortcoming", that BSWNY had not been a large-volume carrier prior to the time of its bid for the Upstate New York experimental contract, obviously was beyond BSWNY's control. Regardless of which bidder would have been successful, the bidder selected would have had to expand its operations significantly just as did BSWNY. Thus, the Report creates a false and damaging impression that BSWNY lacked the proper experience to administer the Upstate New York Program when the truth is that BSWNY's experience for relevant areas met or exceeded those of other bidders. Our present performance rating relative to other carriers attests to BSWNY's qualifications and experience.

A number of other items in the Report also were incorrect. These incorrect items include the following:

A. On page 58, the Report indicates that HCFA was precluded from reviewing and monitoring the implementation of the Upstate New York claims processing system. This is incorrect. BSWNY asked HCFA to review and approve each aspect of testing.

B. The statement on page 59 that "initial implementation resulted in unsatisfactory performance" is not true and does not correspond with the Report's conclusion that the implementation was "smooth and well-run overall".

C. Page 63 and other portions of the Report indicate that BSWNY's staff was inexperienced relative to that of other bidders. However, the need for cost-effective operations and a centralized location virtually assured that any successful bidder would have needed to establish a new location and to employ inexperienced staff. Thus, any contractor would have had staff of approximately the same level of inexperience. Contrary to the statement on page 62, BSWNY did attempt to hire staff from incumbent carriers, and one of a number of steps BSWNY took in this endeavor was to establish a communication system for receiving inquiries from such staff. Unfortunately, our efforts were not successful for a number of reasons:

   (1) One of the incumbents insisted that we not recruit its personnel and requested such an agreement in writing.

   (2) Incumbent carriers moved management personnel that had been involved with Medicare functions to other areas of their operations.

(3) Clerical workers, many of whom earned the "second" income, are reluctant to move when a move might jeopardize the primary income.

In summary, the Report reaches a number of incorrect conclusions, several of which are at odds with factual information contained in the Report and some of which are not supported by fact. We think that the conclusions and the tone should be revised to take the above comments into account.

Thank you for this opportunity to present our views on this important matter.

Sincerely,

John T. Manyon

John T. Manyon
President

JTM/kb
Enclosure

CC: Mr. Barry Tice w/ enclosure
9 Featherstone Court
Baltimore, MD 21236

EDS

EDS Federal Corporation
7171 Forest Lane
Dallas, Texas 75230
(214) 661-6000

August 19, 1981

Mr. Gregory J. Ahart, Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

We appreciate the opportunity to comment on your review of the fixed-price Medicare experiments. The information contained in our enclosed response is intended to assist your staff in preparing a thorough and objective final report.

We found that your draft report is limited in scope, dwells on history and reflects selectivity in research and methodology. Because it does not draw from all available information and uses no valid comparison between our performance and that of other contractors, including the two previous Illinois carriers, it provides no basis on which to draw conclusions. Therefore, it should not be used (without significant modifications) to evaluate the effectiveness of competitive Medicare bidding.

The information contained in our response contains corrections, clarifications and additional material. We are hopeful you and your staff will thoroughly and objectively study our response. We are also hopeful that you will personally ensure your final report incorporates our data. Such interest and action, on your part, will provide a more comprehensive and accurate report to those interested in finding ways to strengthen the Medicare program.

If you, or any member of your staff, have questions on any point contained in our response please call us at any hour. Everyone in my organization is eager to assist any effort to ensure the viability of this very important program.

Sincerely yours,

Lester M. Alberthal, Jr.
President

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SUMMARY

EDS Response To
GAO Draft of A
Proposed Report
On The Success Of
Competitive Fixed-Price
Contracting in Medicare

August 19, 1981

Introduction

The attached EDS evaluation of the GAO draft report on the success of Medicare fixed-price contracting is a result of a review of that report as it pertains to Illinois and the conclusions it draws concerning competitive bidding. It is a detailed item-by-item evaluation of the GAO report. It makes no attempt to address issues pertaining to New York or Maine.

Deficiencies of GAO Report

The deficiencies of the GAO draft report fall into five major categories:

- **Using selectivity, it incompletely portrays EDS' performance.**
- **Its discussion of erroneous payments is misleading because it draws no comparison between EDS errors and those of the previous carriers.**
- **Its general focus is on transition related problems and incorrectly leads the reader to believe they are unique to competitive bidding.**
- **It does not adequately use trends to project future results and it draws questionable conclusions that are based on isolated time frames.**
- **It draws inaccurate conclusions concerning the viability of competitive bidding.**

Performance

Because of the experimental nature of the EDS contract, HCFA established stricter performance criteria for EDS than it established in its Carrier Performance Evaluation Program (CPEP). CPEP is HCFA's program to evaluate cost-reimbursement carriers only. If we were graded, under CPEP standards, we would easily pass.

Illinois Medicare Part B Performance
Based on the HCFA
Contractor Performance Evaluation Program (CPEP)

PERFORMANCE CATEGORY	STANDARD	EDS PERFORMANCE	SCORING POINTS	
			PASS SCORE	EDS SCORE
(Time period Oct. 1980 - Apr. 1981)				
UNIT COST				
Adjusted Unit Cost	$2.90	$1.46	75	172
TIMELINESS				
Assigned claims processed within 15 days	80%	81.1%	75	95.7
Assigned claims processed within 30 days	95%	92.6%		
Assigned claims processed within 60 days	99%	98.9%		
Nonassigned claims processed within 15 days	75%	68.9%		
Nonassigned claims processed within 30 days	90%	88.0%		
Nonassigned claims processed within 60 days	98%	98.2%		
(Time period Jan. 1981 - Mar. 1981)				
Quality (Payment/Deductible Calculators)				
Assigned claims error rate	2.0%	1.5%	75	90.75
Nonassigned claims error rate	2.1%	4.0%		

Also, in the month ending June 1981, EDS:

- Had a claims inventory of 97,710--the lowest since EDS began administering Medicare for the entire state. This equated to .83 weeks work on hand. This is well below the national average of 1.5 weeks work on hand. It also reflects a dramatic improvement from EDS' highest inventory of 453,987 (6.93 weeks work) in September 1979.
- Had an inventory of claims more than 30 days old of 12,795--13 percent. (The national average is 13.6 percent.) By comparison, in October 1979, EDS had 209,383 claims more than 30 days old (47.3 percent).
- Had a correspondence inventory of 11,944. By contrast, in March 1980, EDS' correspondence inventory was 113,213.
- Had an average review processing time of 16 days. In March 1980, it was 73.2 days, (a 78 percent improvement).

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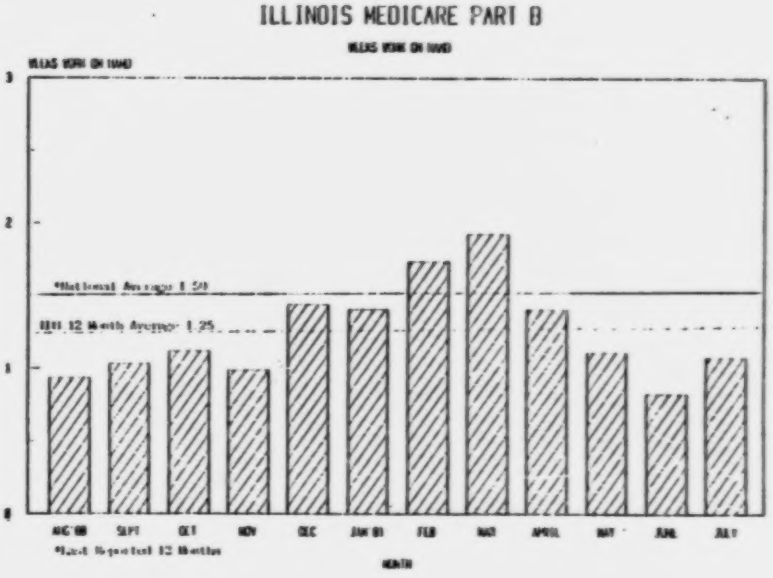
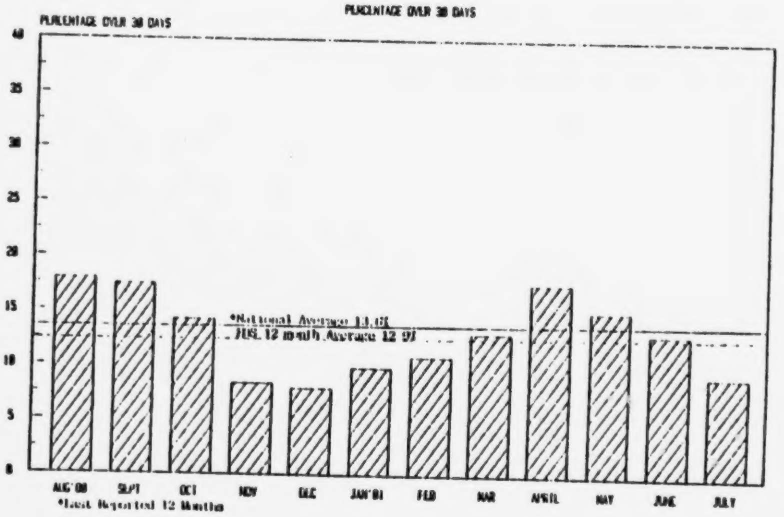
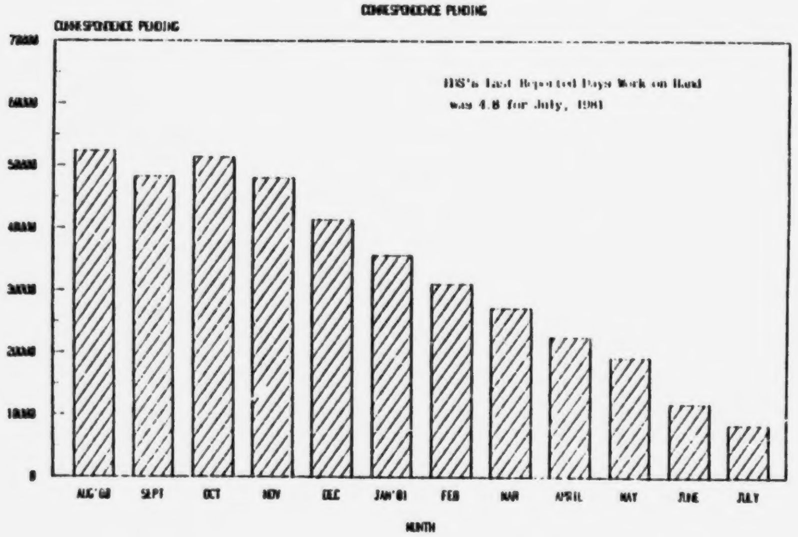

ILLINOIS MEDICARE PART B

WEEKS WORK ON HAND





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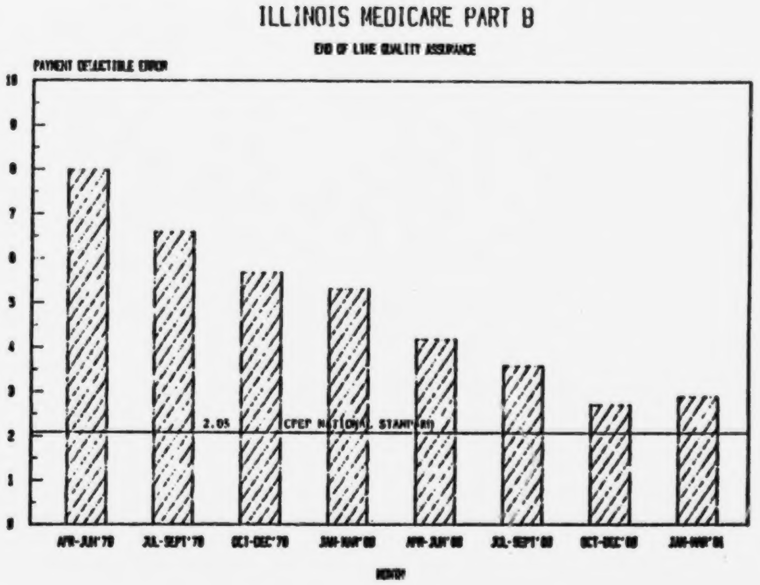
Our quality of claims processing, while it falls short of the HCFA standard, has shown significant improvement.



The most current HCFA statistics that compare all 55 carriers (December 1980) cite our PDER at 2.7 percent (the HCFA standard was 2.05)[1]. Our PDER was equal to or lower than six other carriers' PDER. It was also equal to the last reported PDER of one of the previous Illinois carriers.

It should be remembered that, because of human factors, no computer system is 100 percent accurate. Even at present levels, our staff is operating at better than 97 percent accuracy. Very few clerical operations can make that claim. At our current trend, our PDER should be surpassing HCFA's CPEP standard this calendar year.

When all factors are considered, EDS' complete performance should not be interpreted as "substandard." It should be portrayed as "substantially improved and currently reaching or surpassing HCFA CPEP standards" in the final report.

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[1] In order to meet our unique contract standard, our quality must be better than 27 of the other 54 Medicare contractors.

Payment Errors

Because it does not compare EDS payment errors with those of the previous carriers, the GAO draft report confuses and misleads the reader to believe competitive bidding in Illinois cost the government $60 million. The final report should acknowledge that payment errors are coincidental to claims processing.[1] To put the Illinois cost issue in perspective, EDS' and the two previous carriers' trends must be thoroughly examined and projected through the life of the contract. Comparing these results against the administrative savings the government will realize with its EDS contract produces a net savings, to the government, of $13.2 million.

Comparison of Projected Payment Errors
(Through Sept. 1983 -- in $ Millions)

	Total Errors	Underpayments	Overpayments	Admin. Savings
EDS	106.6	53.3	53.3	20.6
BS/CNA	92.9	46.5	46.5	

Gross Difference[2] ------------------- 6.8
NET SAVINGS --------------------------------------- 13.8

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[1] All Medicare carriers, nationwide, made payment errors of approximately $700 million (Apr. 1979 - Mar. 1981)

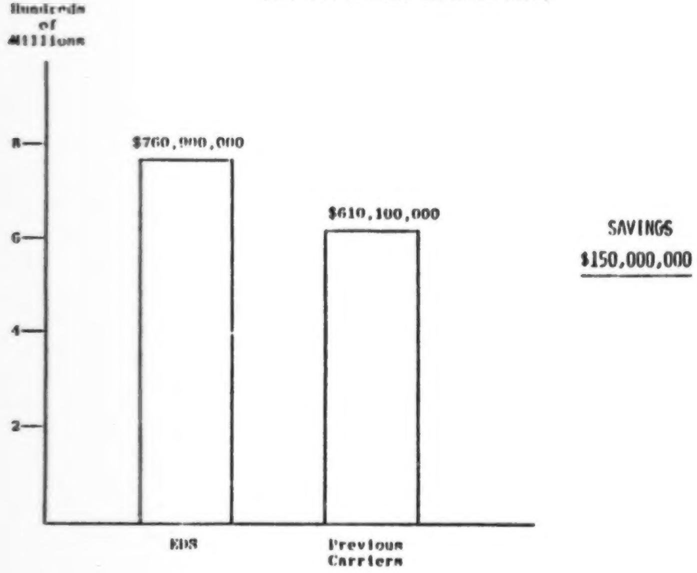
[2] Because of the accepted 50:50 split between underpayments/overpayments and because underpayments are largely offset by adjustments, the gross difference in overpayments is the only adequate basis for comparison.

Benefit Dollar Savings

The GAO draft report also failed to address the significant impact the EDS program has had on HCFA-directed claim denials. Consequently, the resultant reduction of benefit dollars paid by EDS is missing from the GAO report.

In evaluating the experimental program, the differences in denial activities between the two previous carriers and EDS is extremely important. During the period January 1977 through April 1979, the two previous carriers denied 14.2 percent of the total billed charges. EDS has denied 17.7 percent of the total billed charges since it began operations in Illinois.[1] The increase in denial activity that EDS achieved, through September 1980, resulted in a benefit dollar savings of $32.5 million. That level of denial activity is continuing. The difference in denial activities projected over the life of the contract would result in benefit dollar savings of $150.4 million. (See Appendix, Issue 23)

ILLINOIS MEDICARE PART B
BENEFIT DOLLAR SAVINGS
(THROUGH CURRENT CONTRACT LIFE)



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[1] Also, for comparison, HCFA reports reveal that the national denial average for fiscal year 1980 was 11.8 percent. Reports from preceding years reveal similar denial percentages.

The impact of an increase in denial activities applied to all Medicare carriers is dramatic. If all carriers were required to operate as efficiently as EDS in denial activities, the Medicare Part B program would have reduced its cost by $920.3 million during fiscal year 1980.

Conclusions Concerning Competitive Contracting

The GAO report incorrectly concluded that there is little evidence to support the value of competitive contracting. This is due to a limited review and research of available data. This data is included in the attached detailed analysis of the GAO draft. It fully supports the findings presented in the preceding sections. Collectively, it provides evidence of the tangible savings the experimental contract in Illinois has already produced and is expected to produce during the life of the contract.

Just as important, are the intangible benefits the entire competitive experiment has provided. It has and will continue to provide an experience factor, through lessons learned, that will greatly enhance future competitive Medicare contracts.

Recommendations

Since the GAO report addresses the entire issue of competitive contracting, we propose that the GAO include the following recommendations in its final report. These recommendations are based on lessons we learned in Illinois and should benefit future competitive contracting.

- Multiple Sites: We discovered after we began operations in Illinois that a centralized operation could not provide adequate support because of the difficulties in hiring and retaining a large staff with the appropriate skill mix in one area. An operation requiring more than 400 employees can best be administered from two or more sites.

- Medical Procedures Code Policy: There are several existing medical procedure codes. In Illinois the two previous contractors used their own procedure codes rather than the one most commonly used by medical providers. Since it was impractical for EDS to use two separate procedure codes, EDS recommended it use the one most commonly used by providers in Illinois. Initially, this caused confusion for us and Illinois medical providers. Because of the variety of procedure codes used nationwide, this problem will obviously reoccur in future contracts. Consequently, we recommend HCFA adopt one universal medical reporting system to be used by all carriers. This will facilitate transitions in future contracts.

- Transfer of Claims: The two prior carriers left us more than 145,000 pending claims. We had to research inquiries on claims more than a year old. Our congressional correspondence reveals that, for the first three months, 40 percent of services in question were performed before we assumed responsibility for processing claims. Claims processing responsibility should be based on the date of health services. This would provide a smoother transition between contractors and would ensure outgoing contractors maintain their levels of performance.

- Fixed-Rate vs. Fixed-Price: Under a fixed-price contract, contractors are paid one flat fee regardless of variables outside their control, i.e., inflation and claims volume. Because of the inherent financial risk, some bidders are encouraged to inflate their bids. Other are discouraged from bidding at all. Under a fixed-rate contract, payment is made to the contractor per unit processed. This provides a contractor more flexibility, should refine and enhance the bidding process, and ensure more cost-effective program management. We recommend the government closely examine competitive fixed-rate contracting as an alternative to fixed-price contracting.

GAO note: The following is a verbatim et literatim (word for word and letter for letter) copy of EDSF's comments on the 23 issues it raised, except that the page references have been changed to reflect the page numbers in this report and references to exhibits are deleted. We have also changed "EDS" to "EDSF." Because of the length of EDSF's exhibits, they are not included. EDSF uses the following abbreviations, which were not previously introduced in the report.

ADS	automated development system
CNA	Continental Casualty Corporation
CPS	Contractor Performance Standards
CRT	cathode ray tube
CRVS	California Relative Value Study
CSTP	Carrier Systems Testing Project
CY	calendar year
EDP	electronic data processing
EOMB	explanation of Medicare benefits
HCSC	Health Care Service Corporation (Chicago Blue Shield)
IRS	Internal Revenue Service
NABSP	National Association of Blue Shield Plans
NOC	not otherwise classified
OPI	Office of Program Integrity
PARE	payment review
SSA	Social Security Administration
WPS	Wisconsin Physicians' Service

ISSUE 1: reference page 49, paragraph 3, and page 65, paragraph 3

EDSF Response

Concur.

GAO Comment

No comment necessary.

ISSUE 2: reference page 49, paragraph 4, and page 66, paragraph 4

EDSF Response

GAO failed to evaluate the total scope of Medicare dollars (GAO report, pages 5 and 6). Carrier administrative expenses and payment/deductible dollar errors were addressed; however, benefit dollar savings were not presented.

EDSF substantially agrees with the $60 million in payment errors. EDSF internal payment error review reveals that from April, 1979 through March, 1981 EDSF made claims payment errors totaling $58.5 million. During the same period all Medicare carriers made payment errors totaling approximately $700 million.

Payment errors fall into two categories--underpayment and overpayment. As GAO indicated there is generally a 50-50 split between overpayments and underpayments. As a result, the overpayments made by all Medicare carriers during April, 1979 through March, 1981 was approximately $350 million. During this same time period all carriers recovered overpayments totaling approximately $55 million. This reveals that $295 million in overpayments have not been recovered. EDSF does concur with GAO's finding that a net of $25 million of our overpayment errors are unrecovered.

To place the issue in proper perspective, the payment errors of the previous carriers must also be evaluated. EDSF examined the historical performance of all three carriers and projected performance trends through the life of the contract. From this basis it was determined that the payment errors of the previous carriers would have totaled $92.9 million. 1/ It is estimated that the total overpayment errors would have been $46.5 million.

The estimated corresponding overpayments by EDSF for the life of the contract total $53.3 million (50 percent of the total payment deductible errors). As a summary EDSF will pay a net difference of

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1/GAO note: For comparative purposes this represents an error rate of 2.2 percent.

$6.8 million in overpayments. 1/ When compared to administrative dollar savings and benefit dollar savings, the federal government will realize a considerable net savings (discussed in other sections of this report).

GAO Comment

On the basis of its performance to date, we are not aware of an independent valid estimate of any benefit dollar savings resulting from EDSF's contract in Illinois, particularly if EDSF is referring to correctly processed claims. EDSF has based its calculations on claim denial rates, which we believe, based on the quality assurance program analyses and the high rate of review requests and corrected payments made by EDSF, include a considerable number of incorrect or inappropriate denials. As discussed later on pages 149 to 152, these incorrect or inappropriate denials were not factored into EDSF's calculations. Also, there was an unusual and unexplained large increase in claims submitted after EDSF took over as the Medicare carrier in Illinois which we believe would have to be considered in making any meaningful comparisons between EDSF's and the prior carriers' claim denial rates.

We further question EDSF's performance trend calculations for the remainder of the contract. We reported, and EDSF substantially agreed with, a $60.4 million in estimated payment errors through March 31, 1981, which represent an aggregate error rate of about 4.4 percent. To arrive at its estimate of $106.6 million in total errors for the entire contract period through September 30, 1983, EDSF apparently assumed an average payment/deductible error rate beginning April 1, 1981, of 1.6 percent. This is considerably below (almost half) what EDSF experienced during the quarter ended March 31, 1981, when it had a payment/deductible error rate of 2.9 percent. Based on EDSF's estimate of submitted charges during the balance of the contract, a 1-percentage-point variance from EDSF's projection would amount to an additional $29 million payment error, of which half would probably be overpayments, thus eliminating the EDSF projected "net savings" of $13.8 million. The projected savings would be further reduced by the $3 million paid to EDSF to correct the underpayments discussed on page 58.

Although such a significantly improved level of performance is possible, we have no basis for assuming such an improvement will occur.

1/GAO note: In material supporting its comments, EDSF offsets the $6.8 million with the $20.6 million savings in administrative costs to produce an estimated net savings of $13.8 million.

ISSUE 3: reference page 52, paragraphs 1 & 2

EDSF Response

GAO is incorrect in stating that EDSF's performance has remained substandard.

Preliminary HCFA evaluations have indicated that, since the fourth quarter, 1979, EDSF has met 22 of the 72 performance standards. However, evaluations received for one element in the second quarter, 1980 (Program Reimbursement) and 14 elements and one System I Standard in first quarter, 1981 are currently being protested with the HCFA Regional Office. Assuming that these standards/elements are deemed met, and that met elements will serve as a retest for fourth quarter, 1980 failed elements, EDSF will have achieved compliance for 27 of the 70 standards, passing 7 of 12 for fourth quarter, 1980, and 6 out of 12 for first quarter, 1981.

Six of the standards have never passed. They are System I - Informal Reviews Cycle Time, Occurrence Error Rate, Payment/Deductible Error Rate, and System II - Claims Process, Coverage/Utilization and Beneficiary Services. Informal Reviews Cycle Time will be in compliance for July-September, 1981 quarter since July 1981 had a cycle time of 14.97 days and cycle time as of mid-August was about 10 days. Two standards, EDP Operations and Quality Assurance have passed all quarters. The Program Reimbursement standard passed all quarters assuming the reversal of second quarter 1980 based on EDSF's protest.

EDSF's performance standards currently contain 107 elements comprising the seven System II Functional Standards. As passage of all the System II standards requires a maximum passage of 100 elements (93%), including all mandatory elements, the number of standards passed is not an accurate reflection of EDSF's performance.

The number of elements passed is a more representative indication of EDSF's performance.

From the fourth quarter, 1979 through the first quarter, 1981, preliminary HCFA evaluations indicate that EDSF has achieved compliance for 545.5 of the 650 elements evaluated (83.92%). Sixty-eight (68) of the 107 elements (63.55%) have achieved compliance in all quarters. In addition, evaluations for 15 elements are currently being protested. Passage of these elements will bring EDSF's total element compliance to 572 out of 650, or 87.8%, with 74 elements (69.16%) of the 107 achieving compliance in all quarters.

GAO has stated that EDSF's performance has been substandard. There is no measure of "standard" provided, and remains unsubstantiated, as there was no direct comparison to other carriers presented. Other cost-reimbursement carriers are evaluated on a bonus/penalty point basis under CPEP. EDSF is evaluated on a pass/fail basis on 107 elements, 45 of which are not included in CPEP. To accurately evaluate how EDSF compares to other carriers, assuming that the performance of other carriers defines "standard," it would be necessary to evaluate EDSF under the CPEP criteria. Having not taken this necessary step, GAO has no basis for its assessment.

Relative to fixed-price contracts, some comparisons are possible. However, differences still exist and neither carrier has had the level of scrutiny as that placed on EDSF.

Recent evaluations by EDSF of the Contractor Performance Standards (CPS) raise serious questions as to the credibility of performance standards and methodology used. The subjects addressed are:

--Catch 22 Situation - Sacrificing the compliance of one (or more) standards or elements to achieve compliance in another due to implicit mutually exclusive nature of some of the standards.

--Double Jeopardy - The potential exists to fail multiple standards or elements because of an inadequacy in one function. As an example, the function of adjustment claims has nine different potential impact standards or elements.

--Method of Evaluation - Evaluation methodology in some situations is vague or room for interpretation of the method is so wide, that the substance of the element is distorted by the form of the resulting evaluation methodology.

--EDSF CPS vs. CPEP Differences - Briefly the following differences exist between the two performance evaluation methods:

- Occurrence Error Rate not Evaluated under CPEP.

- Forty-five (45) EDSF elements in CPS are not included in CPEP.

- CPEP includes a bonus/penalty point system. CPS is neither [sic] pass or fail.

- CPEP is an annual review. CPS is a quarterly review.

An evaluation was completed on how EDSF would perform under CPEP. As a summary for the first quarter 1981, EDSF was in compliance on 4 of 12 standards using CPS. [1] By comparison, 10 of 12 standards would have been in compliance under CPEP. This comparison further illustrates the stricter evaluation criteria for experimental contracts.

GAO Comment

Failure to meet over 60 percent of specific contractual performance standards and being subject to financial penalties of almost $3 million is, in our opinion, indicative of substandard performance under the terms of the contract, which has consistently been the criteria by which all three experimental part B contractors are evaluated. The RFP and the subsequent contract EDSF signed clearly state the standards to be used.

We have not compared EDSF's performance with that of cost reimbursement contractors, although some comparisons particularly in workload statistics are available. As EDSF pointed out, the CPEP criteria and methodology are different in many respects from the criteria and methodology used by HCFA in the experiments. Also, the CPEP standards were not effective until October 1, 1980, and only certain sections--mainly the statistical standards involving unit costs, timeliness of claims processing, and quality assurance results--would be readily available for comparison.

We have not completed a thorough analysis of CPEP's criteria or procedures principally because CPEP involves an annual evaluation which will be applicable for the year ended September 30, 1981. In view of EDSF's position (see p. 106 of this appendix) that it would easily pass the CPEP standards, we believe several observations are warranted:

1. The time period chosen by EDSF for comparison is October 1, 1980, to April 1981 for timeliness and January to March 1981 for quality. While the October 1, 1980, date coincides with the effective date of CPEP, it does not cover the first 18 months of EDSF's operations in Illinois, which we believe is essential in evaluating performance under the experimental contract.

2. EDSF presented its standing relative to only three statistical standards in CPEP. Since neither EDSF nor any other

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[1] GAO note: As noted previously in its comment on the issue, EDSF protested this determination. According to HCFA, it has now decided that at least 6 of the 12 contract standards during the first quarter of 1981 were met. EDSF still has an opportunity to correct two additional System Two standards that were initially failed during this quarter (see pp. 86 and 87).

part B contractor had been formally evaluated at the time of our fieldwork using the remaining performance criteria in CPEP, additional comparisons would be virtually impossible and incomplete.

3. One of the three performance categories chosen by EDSF for comparison is unit cost. We believe this category is irrelevant in a fixed-price contract. Also, EDSF shows its unit cost based on the contract price, rather than its actual operating costs. Although we believe neither is relevant in terms of EDSF's performance, EDSF's operating costs have been almost twice the amount of contract payments (see p. 65).

4. The second performance category presented by EDSF is timeliness of claims processing. As shown in appendix II, under the EDSF contract there are two System One standards pertaining to this category. Except for a deterioration of performance during the quarter ended March 31, 1981, which EDSF protested as being due to factors beyond its control, it has passed one of the two contract standards since the quarter ended September 30, 1980, and has passed the second contract standard for the December 31, 1980, and March 31, 1981, quarters (the same period selected by EDSF to evaluate its performance under CPEP). Therefore, while EDSF's performance in the timeliness of claims processing category was a matter of concern during the first 15 months of the contract, performance has improved and the question of whether contract or CPEP standards should be applied for the evaluation period selected by EDSF 1/ seems to us somewhat academic.

5. Under the quality category, EDSF presented its payment/deductible error rate, which for the quarter selected by EDSF was 2.9 percent. For this category under CPEP, HCFA provides separate standards for assigned and unassigned claims. 2/ Although EDSF's overall error rate was about 50 percent higher than the CPEP standards, the CPEP methodology would have given EDSF a score of 90.75 (passing is 75).

There is no question that the CPEP standards in the quality category are more liberal than the fixed-price contract standard. Although comparative data for the quarter selected by EDSF were not available, HCFA statistics for the quarter ended December 31, 1980, showed that EDSF, with an overall payment/deductible error rate of 2.7 percent, would have passed CPEP with a score of 87.25.

Of the 50 carrier/location combinations listed in the HCFA statistics, EDSF ranked 40th and 43rd, respectively, in terms of highest error rates for assigned and unassigned claims. There were 35 carrier/location combinations that ranked better than EDSF in

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1/The quarter ended June 30, 1981, was not included in EDSF's analysis.

2/On assigned claims the carrier pays the provider directly, whereas on unassigned claims payment is made to the beneficiary.

both categories. Of the 14 that ranked below EDSF in either or both categories, only 3 failed the CPEP standard. Further, in terms of total scores, 7 of the 14 had the same or lower score than EDSF. Thus, EDSF ranked in the lowest 20th percentile of all part B carriers in the quality category under CPEP.

EDSF also states that the number of contract standards passed or failed is not an accurate reflection of performance, claiming that the number of individual elements comprising each standard which are passed or failed is a more representative indication.

For essentially two reasons we do not agree with EDSF that the elements provide a more representative indication of performance. First, about one-third of the individual elements are not evaluated by HCFA each quarter. This may be because of workload considerations or because some elements do not apply in each quarter of the year. In such cases, the elements are "deemed met" but are not evaluated. For example, at least 69 of the approximately 212 elements applicable in the quarters ended December 31, 1980, and March 31, 1981, were not evaluated but were deemed met. Second, individual elements also differ as to their importance. 1/ For example, EDSF naming a system security coordinator, and thus passing one of the elements in HCFA's monitoring plan, is not as important as being able to correctly handle beneficiary or provider requests for reconsiderations of initial claims determinations. Simply stated, while the contract monitoring plan does give weight to the relative importance of various elements, the analysis that EDSF suggests is more representative does not.

ISSUE 4: reference page 53, paragraph 1

EDSF Response

Through quarter-end December, 1980, EDSF is subject to $2.19 million in damages, pending the outcome of a protest of the second quarter, 1980 Program Reimbursement standard. Passage of that standard will reduce the total penalty from $2.19 million to $2.14 million, and from $1.0 million to $.99 million for the System II standards.

EDSF has been notified of the non-compliance on 33 standards of 42 standards failed for the October 1, 1979, to December 31, 1980 time period. This represents assessments paid of $1,742,250.

1/Under the HCFA monitoring plan, certain elements were designated as "mandatory" and must be passed in order to meet the contract standard. Other elements are assigned point values. Once all mandatory elements in a functional area are met, the points achieved for the remaining elements are totaled. EDSF has to receive at least 90 percent of available points to pass a particular standard.

GAO Comment

No comment necessary.

ISSUE 5: reference page 54, paragraph 1, and page 76, paragraph 4

EDSF Response

GAO presented incorrect facts related to the experience level of EDSF's staff.

During the July, 1978 through March 31, 1979, implementation period, EDSF had a staff of up to 23 individuals responsible for the implementation effort, 18 on-site full-time in Des Plaines, and 5 either part-time in Des Plaines or in a consulting capacity. Twenty of these people brought with them a combined total of 120 years Medicare experience, 4 of whom had upwards of 10 years experience each. All of the implementation staff had previous Medicare private health insurance and/or other health care experience. In addition, EDSF had a technical support staff in Dallas, Texas numbering 35, with a combined total of more than 115 years experience with the EDSF Medicare systems and the Medicare program.

Ten (10) of the 16 management staff cited in the proposal have been involved in the EDSF operation, 6 on-site and 4 as consultants. Eight (8) other key individuals, with a total of over 48 years Medicare experience, as well as other health insurance experience, were placed in the remaining positions.

GAO Comment

We hope the changes we made on page 54 clarify our position. We did not intend to criticize the EDSF staff's experience in setting up or testing its Medicare data processing system before going operational in April 1979. We were aware that some of its transitional staff (July 1, 1978, to March 31, 1979) and its technical support staff had experience with Medicare system implementations.

What we are addressing is the lack of Medicare experience in key managerial positions after claims processing operations began on April 1, 1979, and the related concern over EDSF's deviation from its technical proposal regarding the specific personnel stated to hold these key positions. For the most part we did not review the qualifications or experience of EDSF's managerial staff. We did, however, discuss this issue many times with the principal HCFA staff responsible for monitoring EDSF's performance. As we state in this report, HCFA was critical of EDSF's experience. The following excerpt from a March 19, 1980, report from HCFA's Chicago Regional Administrator highlights the lack of experience at the Illinois site.

> "EDSF's lack of total experience, combined with the consolidation aspect mentioned above, were the greatest contributors to the problem. The subsequent high turnover rates and hiring problems resulting from the site selection were of a secondary nature.
>
> "* * * the first line supervisory staff did not have any claims processing experience, as a general rule. It was only the managerial staff who had varying levels of experience with Medicare. First line supervisors were, for the most part, new hires since EDSF did not attract such personnel from the incumbents, primarily because of low pay, the distance factor, and counter offers from the incumbents."

Further, in reference to EDSF's comment that 10 (rather than 3 cited by HCFA) of the 16 management staff cited in the proposal have been involved in its operation, we believe EDSF's explanation is misleading. The position descriptions and responsibilities cited by EDSF for these 16 key individuals did not, in our opinion, call for the involvement of these individuals as consultants, but rather their full-time, on-site presence. For example, EDSF's technical proposal describes the utilization review staff as reporting directly to the director of medical administration and having

> "primary responsibility for analyzing post-payment utilization review reports, identifying potential overutilization and/or fraud, developing cases to support or deny allegations, and recommending actions to the director of medical administration."

It further names and provides a resume of the individual who would head up this key department. EDSF's argument that this individual and three others were involved as consultants is, in our opinion, inconsistent with the descriptions in the proposal.

Regarding the six on-site management staff cited by EDSF, we are aware of only three being involved during the first year of operations, particularly in the capacities named in the proposal. Further, although EDSF stated that the other three (named in the proposal as director of medical administration, manager of medical policy, and manager of systems support) worked on-site, documentation given us by several EDSF managers names other individuals as having filled these positions during the first year.

ISSUES 6 & 7: reference page 54, paragraphs 3 & 4

EDSF Response - #6

GAO presented incorrect information related to the compatibility of EDSF systems and HCSC's codes.

The HCFA RFP indicated "system now in place at the existing Carriers are versions of the 1964 CRVS at CNA, and the 1964 NABSP at HCSC." (Page 128). EDSF was not given the opportunity to view procedure codes used by HCSC prior to submission of the proposal. EDSF's prior experience with carriers or private businesses indicated that NABSP procedure codes were compatible with EDSF's claims processing system.

EDSF first received a copy of the HCSC codes in August, 1978 from Tom Flynn of the Regional Office. However, upon receipt of the procedure codes used by HCSC, it was noted that they had very little in common with the original version of 1964 NABSP codes. For example, a routine hospital visit in 1964 NABSP is 9024, while HCSC's code for the same service was D309, and for a routine office visit, the 1964 NABSP code is 9004, while HCSC's code was D794. Similar disparities between procedure codes and descriptions existed in all sections of the HCSC procedure code listing. In short, the HCSC version of 1964 NABSP in no way resembled the original version of 1964 NABSP procedure codes.

Despite the extensive changes in HCSC procedure code system from 1964 NABSP, EDSF's claims processing system was compatible with the HCSC procedure code system. In fact, because of the lack of a common procedure code system among Medicare carriers, EDSF's system currently accommodates multiple coding systems (as many as 8).

After evaluation by EDSF of the HCSC coding system, it was determined that a new coding system was required. The primary basis for this decision was information (or lack of information) received from HCSC. The procedure code listing received by EDSF was in alpha-numeric sequence with little or no organization related to consecutive numbering of codes within a procedure code grouping. It was difficult to find, as an example, all procedure codes and corresponding descriptions related to 'VISIT' procedure codes. Despite EDSF's request to HCSC for a claims examiners procedure code and guidelines manual, HCSC refused to provide EDSF with a complete manual. After a number of requests were rejected, EDSF requested HCFA Regional Office obtain a copy of HCSC's manual. They were also unsuccessful in obtaining a copy for EDSF.

In addition it was noted that CNA had procedure codes (and descriptions) for which there was no equivalent HCSC procedure code. Based on the organization of HCSC procedure code, merging of CNA codes would have been difficult.

EDSF designed the procedure code system so procedures were organized within a logical medical grouping. Within the grouping, procedure codes were numbered consecutively for ease of use internally and by the provider community. The success of this design and acceptance by the provider community is evident through the current claim pre-coded rate of about 40%.

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EDSF Response - #7

GAO's quotes of EDSF personnel are inaccurate.

The former director (George McElvain) was only minimally involved in the technical proposal process and as a result was not aware of the extensive changes in HCSC's coding system. EDSF submitted its proposal on May 31, 1978. It was not until members of the EDSF implementation team received the HCSC procedure code list in August, 1978 and began the procedure code mapping task that the disparities between HCSC's codes and the original version of 1964 NABSP codes were discovered.

Related to CPT-4 as an alternative coding system, an EDSF official told GAO that they hoped HCFA would approve the use of CPT-4. According to George McElvain, HCFA Regional Office recommended to HCFA Central Office that EDSF be allowed to use CPT-4 as the procedure coding system. EDSF's first official written request to HCFA for use of CPT-4 procedure codes was in November, 1978.

The HCFA Central Office subsequently denied EDSF's use of CPT-4 procedure codes. This notification was received in early January, 1979. A letter from George McElvain to William Cohen of the American Medical Association dated January 8, expresses the fact that our request had been denied. EDSF had been in receipt of a letter from Mr. Cohen indicating strong support for the use of CPT-4 procedure codes in processing Medicare Part B claims in Illinois. This letter was dated December 19, 1978.

GAO Comments to Issues 6 and 7

We based the statements concerning EDSF's procedure coding plans on numerous meetings with HCFA personnel and various memorandums concerning this subject, and particularly on oral and written information supplied by EDSF's program support manager and its former program director, 1/ whom we met with numerous times during our review. The individual EDSF discussed above (Mr. George McElvain) was replaced in late 1979, and we never met with him.

EDSF's program support manager advised us in writing that Blue Shield's coding system was not compatible with the EDSF system. Further, EDSF's former executive program director told us on April 11, 1980, that EDSF wanted to use CPT-4 even before it submitted its proposal to HCFA. He said EDSF knew Blue Shield's coding system "was a mess" and added that this knowledge and desire for CPT-4 prompted the procedure coding questions EDSF asked of HCFA at the April 18, 1978, preproposal conference in Chicago.

Although EDSF stated in its comments that the disparities between the coding systems were not discovered until August 1978, we believe that from a historical standpoint EDSF's scenario is incorrect and inconsistent with discussions we previously had with key EDSF personnel. In this regard, the record of the preproposal conference indicates that a copy of Blue Shield's procedure coding system was available that day (April 18, 1978) and that other copies were available at HCFA offices in Chicago and Baltimore. We further confirmed this with one of the HCFA officials who conducted the conference in Chicago.

ISSUE 8: reference page 55, paragraph 3

EDSF Response

In converting the two procedure coding structures of the previous carriers, EDSF had to perform an in-depth cross-reference to the single coding system. As GAO noted (GAO Report - page 55), HCFA Regional Office approved EDSF's procedure code system.

There are 26 groupings among the EDSF procedure code system. Additions have been made to 21 of the groupings. Contrary to the assessment by EDSF's former medical advisor, no procedure code groupings were left out at implementation.

There have been rapid advancements of procedures performed by physicians during the last few years. As a result, a constant and continuous review, and evaluation of procedures is conducted to determine the need for additional codes. Even with this review, it is possible for procedure codes for any carrier to be out-of-date or impractical because of rapid medical advancements.

1/The former executive program director we are referring to is now the regional manager in charge of the Illinois part B operations.

Not Otherwise Classified (NOC) codes are available within each grouping and in some sub-groupings to accommodate coding of new or unusual procedures.

As of July 1981 over 3,800 procedure codes and 9,400 type of service/procedure code combinations have been established by EDSF for use by the Illinois provider community.

Contrary to the former medical director's assessment, EDSF staff did not have difficulty understanding the organization of the system.

GAO Comment

To be consistent with EDSF's comments on its procedure groupings, we have clarified our statement in the report concerning the former medical director's assessment (see p. 55). She specifically referred to the cardiovascular grouping or section, in which three subgroupings or subsections were left out.

Although EDSF disputes the former director's assessment of the system's organization, her assessment is supported by similar assessments by HCFA regional staff, and by the former manager of EDSF's medical division. The system was described as being confusing not only to EDSF clerical personnel, but also to doctors and providers in Illinois because of its organizational problems. Additionally, during the last several months of 1979 and early 1980, EDSF was seeking HCFA approval of many revisions to its coding system, including a new coding manual--further evidence, in our opinion, of the validity of the earlier assessments by EDSF and HCFA personnel.

ISSUE 9: reference page 57, paragraph 2

EDSF Response

GAO states that the Model Office in the other two experiments were successful and implies that EDSF's was not successful. GAO's implication is in error as evidenced by the following facts.

EDSF submitted a comprehensive written test plan to HCFA on January 9, 1979, outlining the testing necessary which would encompass all phases of processing. On February 16, 1979, EDSF received HCFA's written approval and concurrence with the plan.

Additionally, as stated in this letter by Judith Stec, Joan Fosler of HCFA Central Office and Regional Office staff spent several days on-site reviewing the Model Office plan and status. EDSF was not informed of any problems. The review took place between February 6, 1979, and February 9, 1979. The agenda items of the initial meeting were CSTP goals, CSTP schedule, Model

Office status, and system training for HCFA Central Office and Regional Office personnel.

The Model Office testing plan was an expansion of prior EDSF Medicare system implementations. It was followed by a complete and comprehensive test package and sign-off list.

A total of 913 items under 11 categories and 50 subcategories were identified as test and/or sign-off items. The sign-off documentation as of March 17, 1979 shows 856 items or 94% completed.

EDSF does not have evidence of additional items signed off prior to the March 24, 1979 input of live claim data. However, discussions with EDSF personnel on-site for Model Office testing indicates that the final sign-off percentage was over 99% complete.

Over 20 separate test computer cycles were completed during Model Office and over 36,800 claims were entered for processing in Model Office. Normally, less than 5,000 claims have been entered during Model Office of other Medicare implementations.

As a summary, the Model Office testing was highly successful. The problems encountered during the first several months of the carrier operation were not related to computer system problems.

GAO Comment

We have revised this section to clarify our findings on HCFA and EDSF activities to test the entire claims processing system. Because of EDSF's concern, we have deleted reference to the success of its model office testing in the other two experiments.

We were aware that HCFA approved the model office testing plan. We stated that HCFA's staff told us they did not observe the testing, as we also reported for New York (see p. 37).

See pages 130 to 132 for our more detailed comments on EDSF's responses regarding the model office testing (issues 10 and 11).

ISSUE 10: reference page 57, paragraphs 1 & 3

EDSF Response

GAO's general statements related to simple and not representative claims, and procedure codes availability are inaccurate.

EDSF maintained input test documentation for approximately 6 months after implementation. At that time, it was decided that this data was no longer necessary and could be disposed. This decision was consistent with other similar EDSF implementations and confirmed through recent conversations with staff at other Medicare accounts.

HCFA was incorrect in stating that "these tests were probably very simple and not representative of actual claims EDSF would receive." As evidenced by the details of the Model Office plan, the comprehensive list of test items, and over 36,800 claims entered during Model Office, very complex and representative testing was completed.

During Model Office, EDSF received approximately 15,000 claims which had been processed by HCSC. Most of these claims were keyed during Model Office and were representative of Medicare claims in the State of Illinois. In order to adequately test and debug the system, EDSF also designed and developed test claims and situations which were appropriate to the system specifications being tested.

Certain areas of testing were more difficult to test. Specifically the Eligibility and Query/Response sections of the system require interface with SSA Baltimore and history update and validation. EDSF was not officially operational during Model Office and could not query SSA in Baltimore for eligibility. As a result, certain test conditions and eligibility situations were internally created during testing, and also were tested by HCFA through CSTP conducted concurrently with Model Office.

The procedure code mapping and subsequent approval of procedure codes by HCFA did not have an effect on system testing. The testing of all phases including edits, audits, development, pricing, EOMBs, and reporting were not dependent upon having a procedure code file which was 100% finalized. This procedure code file is continuously being modified to insure that EDSF is staying abreast of technological and Medicare regulation changes. As these modifications are made, appropriate testing is performed to verify that changes are correct and consistent with established policy.

GAO Comment

We believe the changes made on page 57 clarify our findings on this issue. We explain why we do not agree with EDSF's position on the impact of the procedure code availability. HCFA's comments pertaining to unrepresentative claims are consistent with our views and the lack of evidence regarding comparative analyses of processing results.

As stated in our report, EDSF had not retained the input test documentation needed for us to evaluate the completeness of its model office tests. Although EDSF stated it entered over 36,800 claims during the model office test, the information supplied by EDSF in its response to our draft report does not shed any additional light on this issue. It does not describe the tests made, the results obtained, or the corrective actions taken.

With respect to the EDSF comment that 15,000 previously processed claims from Chicago Blue Shield were keyed during the model office test, we were aware of such receipts; however, EDSF's tech nical proposal and HCFA's transition records indicate that these claims were to be used by EDSF's new clerical personnel to practice claims coding and entry. We have not seen any evidence of their use for other purposes.

ISSUE 11: reference page 58, paragraphs 1 & 2

EDSF Response

GAO misinterpreted and misunderstood EDS staff comments about the completeness of Model Office testing.

The EDSF official and his staff responsible for system testing told GAO that the claims processing system is complex and that because EDSF was not processing live claims during Model Office (January, 1979 - March, 1979) EDSF could not query for eligibility to SSA in Baltimore other than for the Carrier System Testing Project (CSTP). As a result, EDSF had to internally create query responses for testing during Model Office. Because of this fact, it was stated "that it was not possible to test all aspects of the system (system meaning EDSF computer system, transmission to/from SSA Baltimore, SSA system processing) during EDSF's Model Office testing." As a result, EDSF, HCFA, and SSA depended on the CSTP to ensure the multiple systems were interfaced and processing properly. It is a fact, that no query/response processing problems occurred after implementation.

As evidenced by the comprehensive Model Office plan, detailed test items and over 36,800 claims entered during Model Office all aspects of the system were tested. This included edits, audits, files, ADS questions, pricing and EOMB messages.

Our review of GAO's assessment of "mailing of unnecessary and confusing letters to claimants" relates to two situations. The first represented letters, which should have been sent to beneficiaries, were instead addressed to the SSA District Office for a brief period of time. As a result, the beneficiary was not affected. The second situation related to claims suspending as letters rather than suspense sheets. However, the letters addressed to beneficiaries were not mailed and instead processed internally. As a summary, the mailing of confusing letters had to be as a result of clerical errors, not system problems.

As a summary, GAO's assessment reflects an apparent misunderstanding of a complex but highly successful, thorough examination of the computer system.

GAO Comment

We have addressed part of EDSF's response to this issue on pages 129 to 131 and have clarified our findings concerning the completeness of model office testing (see pp. 57 and 58).

We disagree with EDSF's statements that no query/response processing problems occurred after implementation. As we discuss on page 134, HCFA's testing project conducted at EDSF during February and March 1980 resulted in processing problems on 25 of the 151 test claims. An EDSF letter to HCFA dated May 29, 1980, indicated that at least six system changes were necessary to correct the query/response problems noted by this test.

As discussed on page 58 and addressed by EDSF in issue 12 (see below), EDSF's records indicated that 182 system changes were made during the first 15 months of operations. After reviewing the documentation available on the 182 changes, we identified 35 which required a detailed explanation from EDSF's technical services staff to determine whether the problems noted could have been corrected before implementation. For 10 of the 35 system changes, EDSF's technical services director told us that the problems requiring the changes probably were not tested for during the model office test or were overlooked. Only two of these changes were for EDSF's internal processing situations (see EDSF's issue 12).

ISSUE 12: reference page 58, paragraph 3

EDSF Response

GAO presented an inaccurate picture of the scope of system problems encountered. They provided no comparison to other Medicare transitions and/or system implementations.

Of the first 182 system changes, 62 were documented as system problems on "Change System Request" forms. Of the system problems, 46 affected EDSF internal processing situations only. As an example, one situation was to establish station numbers for off-line printers in on-line programs. This allowed the on-line audit function to be accessible. Another example was to allow any claim assignment for any batch number on claims system converted from HCSC to EDSF. This was necessary to allow converted claims which suspended to be reentered.

Of the 62 system problems, 16 were identified as situations which could have adversely affected; 1) payment or disposition, 2) claimant interpretation, or 3) incorrect notification or development. The 16 system changes were identifed over a one year period of time. All 7 changes identified during the first 3 months of carrier operations were corrected within three computer system cycles and most were corrected on the same day the situation was identified. Four of the 16 changes were tested and signed off during Model Office and either a later change negatively impacted the system or initial specifications were changed to reflect guideline changes.

As stated earlier, system testing during the transitional period was extensive and situations which surfaced during the year after implementation (if put in the proper perspective) had almost no impact on the beneficiary/provider community. The Illinois Medicare computer system implementation was relatively smooth when compared to previous implementations.

Problems which providers/beneficiaries encountered were dominantly related to clerical processing situations.

To summarize, the 62 system problems can be categorized as follows:

- Internal - 46
- Affect Payment - 2
- No Payment Affect - 7
- Letters - Beneficiary - 1
- Letters - No Beneficiary Affect - 3
- Revised Guidelines - 3

The volume of system changes (problems, enhancements, and regulation changes) initiated were low when compared to experience of previous system implementations. Even lower in number were the volumes of system problems.

GAO Comment

We summarized EDSF's statements on the system changes on page 58. As we point out there, we do not know whether this number of changes is unusual for Medicare system implementations.

ISSUE 13: reference page 57, paragraph 5

EDSF Response

GAO did not accurately present the success of Illinois' 1979 CSTP nor reported the 1980 CSTP score.

HCFA tested with a mini-package of 41 claims. As 5 claims were retested, 46 claims were used in CSTP for 1979. This was a full and valid test package sent to HCFA Regional Office by HCFA Central Office. A similar package was used for New York which contained 45 claims. (see GAO Report, page 37). All system problems were in fact corrected by the end of April 1979. The system change referred to as "incomplete" involved suspending a claim receiving a specific query response which was previously not suspending. As of April 20, 1979, claims receiving this query response were suspended in the form of a development letter. After a short period of time, EDSF concluded for ease of processing to suspend these claims in the form of a suspense document. The second change was implemented on July 2, 1979.

Between April 20, 1979 and the second modification in July, EDSF employees were collecting the letters (which were never mailed) and manually processing these claims as if they had suspended on suspense documents. The problem, therefore, was resolved as stated on April 20, 1979.

As a summary of EDSF's CSTP performance, a passing score of 87.55 was achieved for 1979 during the implementation phase. EDSF continued its excellent performance by receiving the highest score in Region V for 1980 CSTP, scoring 98.83.

GAO Comment

As pointed out on page 57, we have reservations about HCFA's Carrier Systems Testing Project. We are reviewing this project but have not yet issued a report. However, the concerns we have discussed with HCFA principally involve the scoring system, the frequency at which the test is conducted, and the adequacy of the test size to judge the accuracy and reliability of a carrier's processing system.

The HCFA staff responsible for this testing project share some of our concerns and are considering revising the project, particularly the scoring system. Our analysis showed, for example, that a carrier could have a payment error on every test claim and still receive a passing score. Further, regarding EDSF's 1979 test, the HCFA staff told us that some of EDSF's processing problems may not have been detected because the full test was not run--only a mini-package of 41 claims was used. On the 1980 test, errors were made on 25 of the 151 test claims, including 18 payment errors. Despite these errors, EDSF received a score of 98.83, causing the chief of

HCFA's Contractor Review Branch in the region to comment in a June 9, 1980, memorandum:

> "The EDSF CSTP results, in our opinion, cast serious doubts on the viability of CSTP as a monitoring tool of contractor performance. * * * The CSTP, not only assesses the query/reply aspects of claims processing and resultant display of EOMB data, but also many aspects of claims processing i.e., coding, duplicate detection, coverage decisions, and other factors, which are further assessed by our System II monitoring plan and the Part B QA program under System I. EDSF has consistently failed all Standards which can be related to the scope of the CSTP.
>
> "The irony of the inconsistency between CSTP performance and formal monitoring performance is that EDSF did not marginally pass the test. On the contrary EDSF passed the test with a score of 98.83 (out of a possible 100), which is also the highest score to date of any carrier in the Chicago Region. The average number of days to process a CSTP claim was 4.32 days, while the overall average days required during February to process actual claims was 23.2 days.
>
> "Can we conclude that our System I and System II standards have yielded invalid results; that beneficiary, provider, congressional and media problems are imagined; and EDSF is the best performing carrier in the Chicago Region?"

In our draft report, we reported that one of the systems problems noted in HCFA's 1979 test was not corrected until June 1979, although EDSF said it had corrected the problem by the end of April. We have deleted this from the final report in view of EDSF's response that, although the system change was not made until July 2, 1979, actions by its staff to prevent the unnecessary mailing of letters to beneficiaries corrected the problem on April 20, 1979.

ISSUE 14: reference page 59, paragraphs 2 & 3

EDSF Response

It appears that GAO does not understand when or why multiple provider numbers exist. As a result they provide an inaccurate report on multiple listings on the provider file.

Multiple provider numbers for the same provider were transferred from HCSC and CNA to EDSF because of:

1. Private practice and HBP practice;
2. Multiple private practices;
3. Group practices and private practices;
4. Changed addresses;
5. Locality proximity cause a doctor to reside on both of the prior carriers' files.

This was a logical and necessary condition for the following reasons, and for the following reasons EDSF could not delete provider numbers.

1. 1099 IRS, reporting required access by provider number on file.
2. Computer File Conversions - history; pricing; in-process claims.
3. Review and Fair Hearing informational requirements.
4. Reasonable Charge Profile Build considerations.
5. Claim pricing considerations.

If the same or similar service is billed for on the same day or range of days, the EDSF system will detect the duplication, regardless of the provider number used. The EDSF system will suspend these duplicate claims if the provider numbers are the same or if the provider numbers are different.

Multiple provider numbers for the same provider will be treated as if two distinct providers were billing, and the claim will suspend for manual review. Therefore, multiple provider numbers do not detract from the system's ability to detect duplicate claims.

To our knowledge HCSC and CNA could not prevent paying claims as duplicates of claims processed by the other carrier, as there was no interface. Since EDSF is the sole carrier for the state, the duplicate detection process has been enhanced.

GAO Comment

Statements from HCFA's contract review staff and evidence gathered by us in our assessment of duplicate payment situations refute EDSF's claims. HCFA staff told us of several provider numbers which should have been deleted from EDSF's file. Also, one provider number that we inquired about, and was reported by EDSF system personnel to be inactive, was found by us to have been used and payments made based on it many months after it was reported to be "inactive."

Our analysis of duplicate payments made by EDSF for the same claims revealed numerous situations in which the claims were paid without evidence of any suspension as a potential duplicate for manual review. By design, our analysis of beneficiaries' claims history required several data on each claim to be identical--primarily, date(s) of service(s), billed amount, and number of services. Further, for the situations discussed here, the procedure codes, place of service, and type of service also matched. The only essential difference was provider number.

We used several other variations on the above data elements and found many other cases of duplicate payments. We believe the analysis described above, where only the provider number differed, while dates, billed amounts, procedure codes, number of services, type of service, and place of service all matched, clearly refutes EDSF's statement that "multiple provider numbers do not detract from the system's ability to detect duplicate claims."

ISSUE 15: reference page 60, paragraph 1

EDSF Response

GAO was mistaken in stating that EDSF did not have an operational Program Integrity unit until August 1979.

EDSF employed a Program Integrity staff in the Program Integrity functional area prior to carrier implementation in April, 1979. As a result, these functions were operational from the beginning of EDSF's operations. EDSF hired the first individual for Program Integrity in February, 1979. One (1) additional individual was hired for Program Integrity in July, 1979 and 8 were hired in August, 1979.

An attached exhibit illustrating communications between HCFA and EDSF in March, 1979 substantiates the fact that EDSF had an operational Program Integrity department.

The EDSF Professional Relations department contacted all Teaching Physician Hospitals in Cook County in July, 1979 and downstate hospitals shortly thereafter. Procedures for performing the Teaching Physicians Audit were available in June, 1979 and revised in November, 1979. Audits were initiated by EDSF after some clarification of which teaching physicians' hospitals should be audited was received from HCFA.

The post-payment utilization function is highly dependent on computer generated reports. The reports received from the prior carriers were of little value since HCSC and CNA's procedure codes and provider numbers had to be manually mapped to build a PARE (Payment Review) case. To accommodate better accessibility to provider history, it was necessary to run the EDSF post-payment system. This process could not begin until after CNA's claims history was converted on July 1, 1979, and merged with HCSC's claims history. The first reports were produced after third quarter, 1979. The development of PARE cases began shortly thereafter.

GAO Comment

Our statement that program integrity activities went unaddressed was based on information supplied by HCFA and was later confirmed by EDSF's former program integrity manager. EDSF had a program integrity liaison during the early stages of its operations. This, as EDSF points out, was the only program integrity position filled by EDSF during the period February to July 1979.

A carrier's program integrity function includes other significant responsibilities in addition to providing liaison with the HCFA staff. Not all of these activities required development of computer reports. According to EDSF's proposal, its program integrity staff also had primary responsibility for performing beneficiary surveys relating to possible assignment violations by providers and acting on all suspected violations of Medicare policy.

EDSF's teaching physician hospital audits were not started until the first quarter of calendar year 1980. We did not consider the date that EDSF's teaching physician audit procedures were available to be relevant, because EDSF's former program integrity manager told us that EDSF merely obtained the procedures from Continental.

Further, as EDSF described above, 8 of the 10 individuals staffing this department by the end of August 1979 were hired during August. A staff member from HCFA's regional Office of Program Integrity commented in a January 15, 1980, memorandum regarding EDSF passing certain elements of HCFA's monitoring plan relating to postpayment controls and fraud and abuse cases:

> "Although it appears EDSF passed all the elements under review, we do not feel this is an accurate assessment of the Contractor's performance due to the following factors:

1) EDSF's Program Integrity Unit did not become fully operational until November 1, 1979.

2) Many of the cases selected for review were in the initial stages of development and could not be evaluated for timeliness or appropriateness of action.

3) Results of much of the Program Integrity Unit's endeavors cannot be evaluated until next quarter."

ISSUE 16: reference page 60, paragraph 3

EDSF Response

The section referenced in EDSF's technical proposal is page 400-46. It should be noted that GAO misquoted the EDSF technical proposal and interchanged the word 'force' with 'override'. It appears that GAO still does not understand the meaning of each code with reference to use in the EDSF Medicare system.

The report referenced in the technical proposal (page 400-46) has been and is currently being produced daily, contrary to what GAO reported. This report identifies the clerk, the edit forced by edit number, and the volume of edits forced. The report is summarized to the region on entry location level, and account (all claims) level, identifying the edits forced by edit code and the volume of each edit forced.

It additionally reports edits which are not part of the IV-Phase or on-line system, but which fail as the claim is being re-edited by the batch system once the system begins to process the claim. As "on-line" only performs some of the necessary system checks, the majority of which are to detect keying errors, each claim is totally re-edited by the batch system. It performs the same checks as "on-line", in addition to performing other edits which are not part of the "on-line" system.

Any edit failed, whether it was forced past "on-line", or failed in the batch system edits, will cause the claim to suspend for manual review. System edits from errors cannot be bypassed or overridden at this point. The errors must be corrected and the error condition resolved before the claim can continue processing through the system.

During the backlog situation, EDSF maximized the skill level of personnel, and employed a two-step function to enter claims. The first group precoded the claims, and the second group performed a data entry function only. Since the second group was sight-keying, inconsistencies resulting in "on-line" edits (not related to keying errors) were resolved by forcing them through the "on-line" system to suspend in the batch system. There they were adjudicated by trained examiners.

As section 400-46 also states, "The system has the capability to bypass consistency checks...that may be applied on a limited basis from the CRT screen at the time of initial entry to allow a claim to suspend." These edits were not overridden, and as previously stated, the claims were totally re-edited and suspended for manual review by highly skilled personnel. Bypassing the on-line edit by forcing the claim only facilitates the entry function, not the processing function.

GAO Comment

Although EDSF's proposal, page 400-46, uses the words "override codes" and "force codes" to describe the system's ability to bypass certain computer edits, we recognized that EDSF's staff in Illinois did not use the terms interchangeably. Therefore, in questioning EDSF staff about the report, we referred to the proposal.

We were told by EDSF managers, and assured by EDSF's technical services director, that the report, described on page 400-46 of EDSF's technical proposal, was not prepared for the Illinois account.

Similarly, we questioned EDSF and carrier officials at Buffalo Blue Shield in Binghamton, New York. We were assured by both EDSF and carrier officials there that no such report was prepared.

We reviewed the report EDSF refers to above and believe that it does not comply with EDSF's technical proposal. While only EDSF knows exactly what it was referring to in its technical proposal, the report does not document instances where overrides or force codes may be employed by EDSF personnel; particularly, it does not disclose the specific force or override code used, nor the situations involved.

The report is a daily clerk error report which lists by clerk number the batches of claims which contain errors and which system edits were responsible for the error conditions. EDSF's documentation for its production reports states that the "main purpose of this report is to provide data for an on-depth [sic] research of error rates by clerk and for pinpointing the system control codes responsible for increasing or decreasing error rates."

We also discussed this report with EDSF's technical services director. He told us the report did not identify override or force codes and, specifically, it did not distinguish between situations where clerks forced claims into the computer system despite certain error conditions, and situations where clerks corrected the data before entering into the system.

Our review of EDSF's operating manuals also identified situations where overrides can be applied on suspended claims to prevent claims from further suspending. Such situations are not disclosed by the report EDSF has supplied to us and are inconsistent with its comments above, where it states that, after a claim has suspended for manual review, "System edits from errors cannot be bypassed or overridden at this point."

ISSUE 17: reference page 61, paragraph 1

EDSF Response

GAO presented inaccurate and misleading information about hearing officers in December, 1980. In addition, they did not report current hearing officer staff information.

The EDSF technical proposal on page 800-19, states "the offeror will provide, as part of the administrative staff... a Fair Hearing officer and associated clerical support staff. Individuals selected as Fair Hearing officers will be attorneys-at-law, fully qualified to practice law in the State of Illinois. The hearing officers will be qualified to conduct hearings and will either possess a detailed knowledge of or be thoroughly trained in medical terminology and program regulations." EDSF fully expected the Fair Hearings monthly workload to be handled by a single hearing officer.

The Medicare Carriers Manual, Part 3, Section 12016B, states "The Carrier should designate as a hearing officer, an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology. The hearing officer must have a thorough knowledge of the Medicare program and the statutory authority and regulations."

As of December, 1980 contrary to GAO's reporting, EDSF had 4 hearing officers with college degrees, 1 who had prior legal office experience, and 3 who had experience as Medicare claims examiners before accepting Hearing Officer positions. All had extensive Medicare training prior to becoming hearing officers. The Fair Hearing unit was managed by a lawyer who had previously conducted Fair Hearings since April, 1979.

As of May, 1981, EDSF staff of 11 hearing officers consisted of 3 attorneys, 3 individuals with college degrees, and another 5 with claims examination, quality assurance, and supervisory or legal experience.

As a summary, the Fair Hearings staff is fully qualified to conduct hearings and possesses detailed knowledge of medical terminology and program regulations.

A representative of HCFA's Central Office visited the EDSF Fair Hearing unit recently and stated that the quality level of decisions on Fair Hearings was 98%. This was based on his review of cases sent to Baltimore by EDSF.

GAO Comment

We believe the information provided in our December report and this report supports our conclusions that EDSF did not adhere to the commitments made in its technical proposal regarding fair hearing officers. Whether or not EDSF intended to use only one hearing officer, as it now states, has little bearing on the commitment it made. We note with some confusion that EDSF cites an apparent isolated reference to a single fair hearing officer ("* * * a fair hearing officer and associated clerical support staff") when other references are plural, particularly a similar reference on page 900-5 of its technical proposal: "The fair hearings officers and associated clerical support * * *."

HCFA central and regional office personnel reached conclusions similar to ours in assessing EDSF's hearings operation. An April 1981 memorandum from HCFA's Director of the Office of Program Administration states:

> "Obviously EDSF did not adhere to the commitments made in its technical proposal (i.e., individuals selected as fair hearing officers will be attorneys qualified to practice in Illinois). However, our mandating that attorneys now be hired and trained as hearing officers, while bringing the contractor into compliance with its proposal, is not an immediate remedy to the problems--backlogs, the hearings and the quality of the decisions.
>
> "* * * Instead of revamping the hearings staff, I think we should concentrate on bringing the present hearings staff into compliance with the carrier manual (qualified with the ability to conduct hearings)."

The HCFA memo also stated: "We concur with the region's assessment that the individuals hired by EDSF as hearings officers were not qualified to fill those positions when hired." It goes on to point out, however, that "due to on the job training and exposure these individuals are now or soon will be qualified to conduct hearings."

Changes have been made on page 61 of this report to reflect EDSF's description of its fair hearing staff as of May 1981. A further change was made to correct the number of hearing officers with college degrees--previously reported to be three. A fourth individual, who apparently is still enrolled in college, had previously received a bachelor's degree.

ISSUE 18: reference page 63, paragraph 5

EDSF Response

Since Carrier operations began, EDSF's experience has always been that 5 to 6 HCFA Regional Office staff members worked considerably with EDSF. HCFA formalized the monitoring unit based on GAO's December, 1980 report.

The complexity and detail monitoring required of the performance standards established by HCFA for all fixed-price contractors far exceeds the normal performance standards (CPEP - Contract Performance Evaluation Program) established for cost-reimbursement carriers. As an example, monitoring for fixed-price contracts is conducted and formally reported on a quarterly basis, while formal reports are prepared for cost-reimbursement carriers on an annual requirement basis. This factor necessitates an increase in the HCFA monitoring staff requirements for fixed-price contracts.

In addition, 45 elements out of 107 elements, in the System II Standards for EDSF are not included in the performance standards for cost-reimbursement carriers. The monitoring of these elements further increases the need for additional HCFA Regional Office staff.

The Contractors in the region are as follows:

PART B

1. EDSF - Illinois
2. Mutual Medical Insurance, Inc., Indianapolis
3. Blue Cross/Blue Shield, Detroit, Michigan
4. Blue Cross/Blue Shield, St. Paul, Minnesota
5. Nationwide Mutual Insurance Co., Columbus, Ohio
6. WPS Insurance Corp., Madison, Wisconsin

PART A

1. HCSC, Chicago
2. Indiana Blue Cross Mutual Hospital Insurance
3. Blue Cross/Blue Shield, Detroit, Michigan
4. Blue Cross/Blue Shield, St. Paul, Minnesota
5. Nationwide Mutual Insurance Co., Columbus, Ohio
6. Hospital Care Corporation, Cincinnati, Ohio
7. Blue Cross Southwest, Cincinnati, Ohio
8. Blue Cross Eastern Ohio, Youngstown, Ohio
9. Blue Cross Northeast Ohio, Cleveland, Ohio
10. Blue Cross Central Ohio, Columbus, Ohio
11. Blue Cross Northwest Ohio, Toledo, Ohio
12. Blue Cross/Blue Shield United of Wisconsin, Milwaukee
13. Mutual of Omaha Insurance Co.

GAO Response

No comment necessary.

ISSUE 19: reference page 64, paragraph 2

EDSF Response

GAO was incorrect in stating that carriers normally investigate all cases of potential fraud.

The Regional Office staff began monitoring EDSF Program Integrity on performance standards during the fourth quarter, CY1979. The first formal evaluation was for the first quarter, 1980. Because of specific requirements of the Chicago Regional Office and changes in Medicare regulations in 1979, members of HCFA's OPI staff provided instructions for EDSF personnel on assignment violations and other subjects. This occurred in April, 1979 and during the summer of 1979 and again in the fall of 1979. The instructions were of short duration (only a few days). Subsequent discussions have taken place on an individual basis to specific procedural questions.

To our knowledge, EDSF is handling all Program Integrity functions allowed by OPI for any other carrier in Region V. Specifically, EDSF processes all procedures related to fraud cases, abuse cases, assignment violation cases, and post-payment utilization cases.

Per HCFA's EDSF on-site representative, the HCFA Chicago Program Integrity Branch controls and investigates all cases of potential fraud for all carriers in Region V. This function is not normally handled by carrier staffs as reported by GAO. According to the HCFA on-site representative, there are indications that HCFA is moving in the direction of carriers controlling all cases of potential fraud, rather than OPI. Reportedly, this process has started in the HCFA northeast region.

GAO Comment

Our statements concerning HCFA's involvement with EDSF's program integrity functions were based on discussions with HCFA's regional program integrity staff. Because of EDSF's response above, we discussed EDSF's concerns with the chief of HCFA's Region V case development division.

According to the division chief, in March 1980 HCFA turned over the program abuse case workload, previously performed by HCFA, to all carriers in the region except EDSF. Because of EDSF's inexperienced staff, HCFA delayed turning this workload over to EDSF until September 1980, and even then it was a gradual transfer. HCFA's initial fraud development caseload has only been turned over to the smaller carriers in the region. HCFA plans to turn this fraud workload over to Nationwide Mutual Insurance Company (for Ohio) in October 1981 and to Michigan Blue Shield (for Michigan) in January 1982. According to the division chief, they have not decided when EDSF will be given the Illinois workload.

Commenting on EDSF's response to our report, the division chief said EDSF understated the magnitude and duration of HCFA's involvement in this area. He pointed out that EDSF's turnover of program integrity staff has necessitated a good deal of HCFA's efforts in training EDSF's staff on basic Medicare regulations. He said the training was necessitated by EDSF staff's inexperience, rather than changes in Medicare regulations.

ISSUE 20: reference page 64, paragraph 3

EDSF Response

Contrary to GAO's report, problems affecting Social Security Administration offices do not persist.

The volume of written inquiries from the Social Security Administration District Offices have decreased from a high of 4,611 in April, 1980 to a low of 1,237 in February, 1981. This represents a 72.4% decrease in volume. As there are 55 District Offices, this represents a decrease from 3.8 requests per day per office, to 1.0 request per day per office.

The average monthly volume of 2,822 written inquiries received between December, 1979 and August, 1980 has dropped to 1,491 for the November, 1980 to June, 1981 time period.

As a further indication that the workload at SSA offices has dropped dramatically since April, 1980 is the fact that the normal monthly meetings SSA conducts with carriers has been changed to bi-monthly for EDSF.

GAO Comment

Information we obtained from the Social Security Administration indicates that problems still exist regarding EDSF. During the last several months of 1979 and the first several months of 1980, Social Security offices in Illinois experienced over a 20-percent increase in Medicare part B workload compared to the workload experienced with the prior carriers. In fact, for the first 3 months of 1980, the workload was 32 percent higher than during the same months in 1979. As we reported, this workload peaked in May 1980.

The figures presented by EDSF pertain to written referrals from the district offices. Although the volume of referrals did decrease, EDSF's volume remained comparatively high. The two carriers in Region V with comparable claims workload to EDSF are Nationwide in Ohio and Michigan Blue Shield. According to the carriers' beneficiary services report, the following table compares the district office referrals for August 1981.

Carrier	Receipts	Cleared	Pending
Nationwide	800	792	256
Michigan	421	373	125
EDSF	1,248	1,303	111

Thus, EDSF was generating about 1-1/2 to 3 times the referrals as comparable size carriers in the region. We believe our report is accurate; that is, the situation has improved since the spring of 1980, but problems still exist.

ISSUE 21: reference page 65, paragraph 1

EDSF Response

According to HCFA's evaluation, fourth quarter, 1980, no payments were paid to the wrong party. Although the quality rate was 30% in the fourth quarter, based on EDS findings and pending final evaluation by HCFA, 66% were processed correctly for the first quarter, 1981 and 70% for the second quarter, 1981.

GAO Comment

We misinterpreted HCFA's findings as to the reasons for the errors and have changed the report (p. 65) accordingly, deleting reference to payments made to the wrong parties. HCFA's overall conclusion on the quarter ended December 31, 1980, is as follows:

> "Of the 60 cases for which there was sufficient documentation to make an evaluation 43 were inaccurate (70%). As last quarter, it was clear that review determinations were of much poorer quality than initial claims determinations. In 14 cases an amount unrelated to the reasonable charge was allowed (11 were higher than customary and/or prevailing and 3 were lower). Several cases should have been developed for further information but instead additional payment was made without any justification, e.g., previously denied concurrent care is allowed if a physician requests it (no reason given) or asks 'what documentation do you require'. Several cases were 'rereviews' which are not permitted by Medicare guidelines."

ISSUE 22: reference page 66, paragraph 1

EDSF Response

Concur.

GAO Comment

No comment necessary.

ISSUE 23: "Benefit Dollar Savings"

EDSF Response

The GAO draft report discussed the impact of payment errors on benefit dollars but failed to address the significant impact the EDSF program has had on claim denials and the resultant reduction of benefit dollars paid by EDSF on behalf of the government.

The methods used in calculating the data contained in the section entitled Benefit Dollars Savings is detailed below. The data was derived from two HCFA reports; "Quarterly Report on Part B Carrier Reasonable Charge and Denial Activity" and the monthly "Carrier Workload Report" (Form HCFA-1565).

1. Previous Carriers Denial Activity Report

   The percent was calculated from the Carrier Workload Report for the period January 1977 through April 1979 (the last 28 months of operation for the carriers). The Total Amount Disallowed (line 7.0) was divided by the total Covered Charges (line 6.K) plus Total Amount Disallowed (line 7.0).

2. EDSF Denial Activity Report

   The percent was calculated in the same manner indicated above for the period April 1979 through September 1980 (the first 18 months of operation). The denial activity trend continues with current performance.

3. EDSF Benefit Dollar Savings - through September 1980

   The difference between the previous carriers percent (14.2) and the EDSF percent (17.7) or 3.5 percent was multiplied by the total billed amount for the period April 1979 through September 1980 ($927.5 million).

4. EDSF Benefit Dollar Savings - contract life

   The same percent savings (3.5) as calculated above ws [sic] multiplied by the projected total billed amount for the life of the contract--April 1979 through September 1983. The projection assumed a 21.4 percent annual increase in total billed amounts--this is the same annual percent increase experienced by all carriers for fiscal years 1978 through 1980.

5. Total 1980 Benefit Dollar Savings

The total billed amount for all carriers in fiscal year 1980 ($15,598 million) multiplied by the difference in denial activity percents for all carriers (11.8) and EDSF (17.7) or 5.9 percent.

6. Duplicates

The denial activities include duplicate claim denials. To ensure that the EDSF denial percentage was not inflated because of a potential initial increase in duplicate claims, a comparison was made between EDSF and the previous carriers. The total amount denied because of duplicate claims (expressed as a percent of total billed amounts) was examined for the last 12 months of operation for CNA and HCSC and the first 12 months of operation for EDSF. This data was obtained for the Carrier Workload Reports.

Duplicate Dollars as a Percent of Total Billed

Month	CNA	HCSC	EDSF
1	5.0	5.0	3.9
2	5.7	5.8	4.4
3	5.8	4.9	5.3
4	7.8	5.6	5.2
5	7.7	6.0	3.4
6	6.1	5.9	3.3
7	5.7	5.9	4.0
8	5.6	6.2	5.5
9	5.3	5.2	5.0
10	5.2	5.3	4.4
11	5.7	5.9	6.7
12	5.0	7.4	7.4
Average	5.9	5.8	4.9

GAO Comment

Using the above described methodology, EDSF projects a savings in benefit dollars over the life of the contract of about $150 million which will result from its denial activity as compared with the prior carriers (Chicago Blue Shield and Continental).

Under the HCFA reporting system, denials of claims are attributed to six causes: (1) the claimant is not eligible (which nationwide accounts for about 10 percent of all items denied), (2) the time limit for filing a claim had been exceeded (about

2 percent of items denied), (3) duplicate claims (about 33 percent), (4) services not covered (about 27 percent), (5) services not necessary (about 14 percent), and (6) other (about 14 percent). 1/

We agree in principle with the point that EDSF is trying to make, because we believe that carriers' performance in the area of claim denials, particularly with respect to the medical necessity of services claimed, has not received enough attention in evaluating contractor performance under either the fixed-price or cost-reimbursement contract mode. However, we do not agree with either the numbers or methodology used because they failed to consider the reversals of denials and certain other variables which we believe should be considered in comparing different carriers' performance from one time period to another.

Our analysis of the prior carriers' workload reports for July 1977 to December 1978 showed that the denials generally ranged from 13 to 15 percent of the submitted charges. In contrast, except for January through May 1980, when the EDSF denial rates were about 20 percent of submitted charges, the EDSF denial rates generally ranged from 15 to 18 percent. Therefore, it appears reasonable to assume that, over the life of the contract, there will be a 2- to 3-percent difference between the gross denial rates experienced by the prior carriers and those experienced by EDSF.

However, other differences in experience should be considered before drawing any conclusions from these numbers. For example, reported denials are subject to adjustment because they are sometimes later determined to be incorrect or inappropriate. The prior carriers reported reversals (other than for reasonable

---

1/EDSF reported about 20 percent of its denials as "other" and the prior carriers about 10 percent as "other," which makes it difficult to pinpoint the reasons for the differences between its activity and the prior carriers. However, HCFA reporting instructions define "other" to include items denied because of failure to supply additional information requested to enable the carrier to complete processing of the claim.

charge reductions 1/) amounting to 2 to 3 percent of denials. In contrast, since the quarter ended June 30, 1980, EDSF had been reporting such reversals as ranging from 11 to 13 percent of denials. Assuming the reported figures are reasonably accurate, this factor alone could cut the 2- to 3-percent difference by more than half because we would not consider as "benefit savings" money that was later paid.

Another difference in experience is that, during the first year of the EDSF contract, its payment/deductible error rates were 2 to 3 times higher than those of the previous carriers. Such errors include incorrect denials. Although many of these errors were undoubtedly corrected and thus reflected in the reversal statistics cited above, many may not have been corrected and we would not consider unadjusted incorrect denials as a "savings."

Finally, the claims workload and the related billed amounts increased abnormally after EDSF took over Medicare part B in Illinois. As stated in the EDSF comments, the annual increase in billed charges experienced by all carriers for fiscal year 1978 through 1980 was 21.4 percent. However, as illustrated by the following table, for the same period EDSF experienced significantly higher increases as compared with the prior carriers. These increases have not been fully explained.

Period	Billed amounts FY 1978	Billed amounts FY 1979	Percent increase from prior year	Billed amounts FY 1980	Percent increase from prior year	Overall 2-year increase
	(millions)			(millions)		
Oct-Dec	a/$ 92.9	a/$110.7	19	b/$182.4	65	96
Jan-Mar	a/101.8	a/110.3	8	b/177.0	60	74
Apr-Jun	a/106.1	c/112.6	6	b/195.0	73	84
Jul-Sep	a/101.5	b/111.2	10	b/195.0	75	92
	$402.3	$444.8	11	$749.4	68	86

a/Prior carriers.

b/EDSF.

c/EDSF and one of the prior carriers.

1/These are adjustments where the amounts allowed as reasonable charges are increased in favor of the claimant.

Since denial statistics are related to the number and types of claims submitted and the related billed amounts, we believe that an appropriate methodology for comparing claim denial rates from one period to another, and drawing conclusions as to the cause, should consider abnormal variations in billed charges. If doctors or beneficiaries are claiming more and/or different services in one period than in another, more denials could be expected, regardless of any other variable, such as contactor performance.

In summary, in view of the indicated relatively small differences in net denials (about 1 to 1.5 percent) and the relatively large differences in other variables, we cannot draw any conclusions from these numbers one way or the other--much less attribute the difference to the contractors' comparative performance.

Blue Cross
Association
Blue Shield
Association

Merritt W. Jacoby
Vice President - Medicare A
Government Programs Division

676 North St. Clair Street
Chicago, Illinois 60611
312/440-5843

August 18, 1981

Gregory J. Ahart
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

We appreciate the opportunity to review and comment on the draft report of GAO's review of fixed-price Medicare contracting experiments in Maine, Illinois, and Upstate New York. We have no recommendations to offer at this time.

As you may know, we have commented on the proposal to adopt periodic fixed-price competitive bidding for Medicare contracting in a variety of contexts. Based upon our experience as an Intermediary, it has been our position that the procurement technique used in these experiments is not well suited to the nature and goals of the Medicare program. We have doubted the cost saving assumptions associated with the proposal and have also been concerned about the impact that cost-based competitive bidding might have on service and benefit expenditures. At best, we've felt that any administrative cost savings would quite likely be transitory.

Added to these original concerns is our conclusion, drawn from the result of the several "experiments," that this approach to Medicare contracting is much too disruptive and that it disregards the importance of stability and continuity in the administration.

As we read it, the GAO draft report deals with most, if not all, of the concerns that we have raised in the past and cautions, quite properly we believe, that the negative effects of periodic price-based competitive bidding could exceed any advantages. We see this as an appropriate observation on the part of GAO.

We offer one final note, not dealt with in the draft. It is our opinion that a true validation of this technique would require more than one bid and award in a given area. This does not seem to have been contemplated by the HCFA experimental contracts. While this would be impractical at this late hour in at least some of the cases and would run contrary to the advice inherent in your report, it nevertheless suggests to us that the opportunity for true experimentation with this approach has always been problematic. In any event, before the Government seriously considers the approach as permanent Medicare policy, there should be far more evidence of success than is so far available.

Sincerely,

Merritt W. Jacoby

MWJ:lb

cc: J. B. Cardwell

HEALTH INSURANCE ASSOCIATION OF AMERICA

CHICAGO • NEW YORK • WASHINGTON

Paul M. Hawkins
Vice President and
Washington Counsel

Washington Office
1750 K Street, N.W.
Washington, D.C. 20006
(202) 331-1336

August 12, 1981

Mr. Gregory J. Ahart
Director of Human Resources Division
United States General Accounting Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Ahart:

Thank you for the opportunity to review your draft report, "The Success of Competitive Fixed-Price Contracting in Medicare Has Not Been Demonstrated By Existing Experiments."

I am replying on behalf of the eleven commercial insurance companies that have served as Medicare contractors since the beginning of the program in 1966.

We are pleased that your study and conclusions support our belief, which we stated to you at the time you submitted your previous report, that contracting for Medicare administration on a competitive fixed-price basis is not sound policy.

The administration of the Medicare program involves much more than the data processing of claims. Reasonable charge determinations, control of utilization of health care services, and provider and beneficiary relations are facets of such administration that are, perhaps, even more important than data processing capability. All of these elements vary in their complexity depending on the demographics of the area served by a particular contractor, and there is wide disparity in such demographics throughout the United States. In other words, area by area the product, Medicare administration, varies as to its content unlike a finite product such as a rifle. This fact alone would indicate that fixed-price bidding will not work. In addition, Medicare administration is even more difficult to define in consideration of continuing legislative changes and the changing demands of HCFA through revision after revision of carrier manuals, by which the contractor must operate.

Certainly, not to be overlooked is the cost of constantly changing contractors. In addition to the money involved in the transitional costs of changing contractors, there is a disruption of service to beneficiaries and providers and the danger of overpayment of program dollars from the trust funds.

We hope that HCFA will abandon its experiments in competitive fixed-price contracting. Proper management of the cost contracting process can, and does, provide incentives to innovate, to process claims timely on a quality basis, and effectively control program costs.

Again, we appreciate the opportunity to review the draft report, and we support its conclusions.

Very truly yours,

Paul M. Hawkins

Paul M. Hawkins

PMH/jfd

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